

05063

MEDICAL CERTIFICATION

VS A15 (4)
15M 10/57

5105

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY A. A.		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md.		b. COUNTY A. A.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Linthicum		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Linthicum			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 504 S. Hammonds Ferry Rd.				f. STREET ADDRESS 504 S. Hammonds Ferry Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JOHN		First MILLARD		Last ARNOLD, SR.		4. DATE OF DEATH Month May	
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 20, 1894	
9. AGE (In years last birthday) 64 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Asst. Mgr. (rtd)		10b. KIND OF BUSINESS OR INDUSTRY Whitaker Paper		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME John G. Arnold				14. MOTHER'S MAIDEN NAME Mary E. Nauman			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. World War I		17. INFORMANT Mrs. May D. Arnold - 504 S. Hammonds Ferry Rd.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) General Metastasis of adenocarcinoma 154X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) I rectum. DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH Approx 3 years.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12/2, 1958, to 5/19, 1959, that I last saw the deceased alive on 5/19, 1959, and that death occurred at 6 P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Bryant L. Jones, M.D.		M.D.		ADDRESS (Street, city or town, state) BRYANT L. JONES, M.D. 104-Grain-Highway, South Glen Burnie, Maryland Phone: SO. 6-3230		DATE SIGNED 5/20/59	
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/22/59		22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cem.		22d. LOCATION (City, town, or county) (State) Balto., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Hon. J. Pickens & Sons - Balto				ADDRESS 17th		24a. REC'D BY REGISTRAR DATE MAY 21 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Hume			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrars prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5074

CERTIFICATE OF DEATH

Reg. Dist. No.

05065

1. PLACE OF DEATH a. COUNTY <u>A.A.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>A.A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>		c. LENGTH OF STAY IN 1b <u>43 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>203 Eastern Avenue</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>LAURA</u> Middle <u>ELIZABETH</u> Last <u>BALLARD</u>		4. DATE OF DEATH Month <u>5</u> Day <u>23</u> Year <u>1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-26-1907</u>
9. AGE (In years last birthday) <u>51</u> yrs.		10. IF UNDER 1 YEAR Months <u>5</u> Days <u>23</u> Hours <u>19</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic & Hosp. Attendant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>A.A. Co. Md.</u>	
11. BIRTHPLACE (State or foreign country) <u>A.A. Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JOSHUA BALLARD</u>		14. MOTHER'S MAIDEN NAME <u>ESTELLA CROWDY</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>212-32-2375</u>	
17. INFORMANT <u>JOSHUA BALLARD</u>		Address <u>203 Eastern Ave</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <u>coronary heart disease</u> (c) <u>cardiovascular disease</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>10-19</u> , 19 <u>48</u> , to <u>5-23</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>5-23</u> , 19 <u>59</u> , and that death occurred at <u>3A</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Edith Rodler</u>		DATE SIGNED ADDRESS (Street, city or town, state) <u>45 FRANKLIN ST. ANNAPOLIS MD.</u>	
PHYSICIAN'S NAME (Type) <u>Edith Rodler</u>		ADDRESS <u>45 Franklin St. Annapolis, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>5-26-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>ANNAPOLIS-NECK</u>		22d. LOCATION (City, town, or county) (State) <u>ANNAPOLIS-MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>CHARLES E. HICKS</u>		ADDRESS <u>ANNAPOLIS-MD.</u>	
24a. REC'D BY REGISTRAR <u>MAY 28 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>	

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UNIT OF DRAIN

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5106

CERTIFICATE OF DEATH

05068

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>		c. LENGTH OF STAY IN 1b <u>1 1/2 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>XGlen Burnie, Country Club Estates</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>101 North Bend Terrace</u>				d. STREET ADDRESS <u>101 North Bend Terrace</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>TILDA</u> Middle <u>BENGTON</u> Last <u>BENGTSON</u>				4. DATE OF DEATH Month <u>May</u> Day <u>1</u> Year <u>19 59</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 23/1875</u>	
9. AGE (In years last birthday) <u>83</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework(ret.)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Sweden</u>	
13. FATHER'S NAME <u>Daniel Danielson</u>				14. MOTHER'S MAIDEN NAME <u>Eingieorg (unknown)</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Mrs. Lillian Eliassen</u>		Address <u>Same As #2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio-Vascular Disease</u> <u>593X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Nephritis</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. _____ p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>Feb. 1, 19 59</u> to <u>May 1, 19 59</u> , that I last saw the deceased alive on <u>Apr. 25, 19 59</u> , and that death occurred at <u>10: A. M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____							
ACTUAL SIGNATURE <u>James S. Billingslea</u>				M.D. <u>108 Central Ave Glen Burnie, Md</u>			
PHYSICIAN'S NAME (Type) <u>James S. Billingslea</u>				<u>Glen Burnie, Md. 5/1/59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 4/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Pinehurst Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Cloquet, Minnesota</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. V. Singletor</u>				ADDRESS <u>Glen Burnie, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 4 '59</u>	
						24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

CERTIFICATE OF DEATH

I, <u> </u> Registrar, certify that the above is a true and correct copy of the original certificate of death filed in my office.	
Date of Death <u> </u>	Date of Burial <u> </u>
Place of Birth <u> </u>	Place of Death <u> </u>
Age <u> </u>	Sex <u> </u>
Cause of Death <u> </u>	Manner of Death <u> </u>
Signature of Registrar <u> </u>	Signature of Physician <u> </u>
Date of Signature <u> </u>	Date of Signature <u> </u>

-015

jr

5107 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY A. A. Co. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY A.A. Co.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Linthicum		c. LENGTH OF STAY IN 1b Linthicum	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 213 N. Hammonds Ferry Rd.		d. STREET ADDRESS 213 N. Hammonds Ferry Rd.	
3. NAME OF DECEASED (Type or print) First Ada A. Middle Bowers Last		4. DATE OF DEATH Month May Day 17 Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 23, 1870
9. AGE (In years last birthday) 89 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) H.W.		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Howard Frizzell	
14. MOTHER'S MAIDEN NAME Catherine Arbaugh		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		INFORMANT Address Ferry Rd. Mrs. Helen M. Whitehead, 213 N. Hammonds	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Ca of Cervix 171X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hemorrhages (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 15 Apr - 2-3 Apr
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 1940 to 5/17/59 , 19____, that I last saw the deceased alive on 5/17/59 , 19____, and that death occurred at M , from the causes and on the date stated above.			
ACTUAL SIGNATURE Chas. L. Ball Jr.		ADDRESS (Street, city or town, state) 203 W. Maple Rd.	
PHYSICIAN'S NAME (Type) Linthicum Md.		DATE SIGNED 5/19/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF May 21/59	22c. NAME OF CEMETERY OR CREMATORY Lorraine Park	22d. LOCATION (City, town, or county) (State) Baltimore 7, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE W. J. Edmondson		24a. REC'D BY REGISTRAR MAY 20 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Kline			

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VS A15 (4)
15M 9/58

CERTIFICATE OF DEATH

A. A. 100

MA

A. A. 100

Lincoln

Lincoln

113 W. Hammond Terry Rd.

113 W. Hammond Terry Rd.

Mr. A. Bowers

May 19/53

Female

X

April 20, 1970 39

Own home

Lincoln

WVA

Howard H. H. H.

Catherine H. H.

May 19/53

Mrs. Helen M. Whitman, 113 W. Hammond

Baltimore, Maryland

Luxemburg Park

May 21/53

State Registrar
John H. H. H.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

05070

1. PLACE OF DEATH a. COUNTY Anne Arundel 5108 MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Same b. COUNTY Same	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Millersville		c. LENGTH OF STAY IN 1b 2 years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Obrecht Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Edward Moody Bowling		4. DATE OF DEATH May 30th. 19 59	
5. SEX Male	6. COLOR OR RACE W.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/11/28
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Enameler		11. BIRTHPLACE (State or foreign country) USA	
13. FATHER'S NAME Howard Bowling		14. MOTHER'S MAIDEN NAME ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 212-26-4017	
17. INFORMANT Mrs. Carolyn Bowling (wife)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) UASCULAR DISEASE (c), stating the underlying cause lost. (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Paul F. Guerin M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) PAUL F. GUERIN		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 5-31-59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 2, 1959	
22c. NAME OF CEMETERY OR CREMATORY Glen Haven Cem.		22d. LOCATION (City, town, or county) (State) Glen Burnie Md.	
23. FUNERAL DIRECTOR'S SIGNATURE W. R. Singleton ADDRESS Glen Burnie, Md.		24a. REC'D BY REGISTRAR DATE JUN 2 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be filed to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, at its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05071

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel 5109 MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Same b. COUNTY Same	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Severn		c. LENGTH OF STAY IN 1b Over 30 y.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Box 254		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) William Henry Branford		4. DATE OF DEATH May 20th. 1959	
5. SEX M	6. COLOR OR RACE C	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/15/04
9. AGE (In years last birthday) 54 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		12. KIND OF BUSINESS OR INDUSTRY Severn Md.	
13. FATHER'S NAME Phil. Branford		14. MOTHER'S MAIDEN NAME ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 215-16-6301	
17. INFORMANT Mrs. Rachel Branford (wife)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 420.1 DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH Sudden	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Gustave H. Faubert		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Gustave H. Faubert, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 5/20/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/24/59	
22c. NAME OF CEMETERY OR CREMATORY Brooklyn - Md		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Marshall P. Hayes		ADDRESS 635 N. Gilman St	
24a. REC'D BY REGISTRAR MAY 21 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be filed to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

0001

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

STATE OF MARYLAND
DEPARTMENT OF HEALTH

Name		Age		Sex		Race		Date of Birth		Date of Death		Time of Death		Place of Death	
John Doe		45		Male		White		1910		1955		10:00 AM		Home	
Cause of Death															
1. Myocardial Infarction															
2. Coronary Atherosclerosis															
3. Hypertension															
4. Diabetes Mellitus															
5. Chronic Kidney Disease															
6. Chronic Obstructive Pulmonary Disease															
7. Chronic Liver Disease															
8. Chronic Alcoholism															
9. Chronic Mental Disease															
10. Chronic Drug Abuse															
11. Chronic Infection															
12. Chronic Trauma															
13. Chronic Poisoning															
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CERTIFICATE OF DEATH

Reg. Dist. No.

05067

5075

1. PLACE OF DEATH a. COUNTY <i>AA</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>AA</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>10 Annapolis</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>U. S. General</i>		d. STREET ADDRESS <i>1310 Riverview Ave</i>	
3. NAME OF DECEASED (Type or print) First <i>Charles</i> Middle <i>E.</i> Last <i>BRANZELL</i>		4. DATE OF DEATH Month <i>May</i> Day <i>14</i> Year <i>1959</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 7th 1891</i>
9. AGE (In years last birthday) <i>67</i>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Baker U.S. Navy</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Baker</i>	
11. BIRTHPLACE (State or foreign country) <i>Annapolis Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>John H. Branzell</i>		14. MOTHER'S MAIDEN NAME <i>Hester Ann Woolford.</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Nina E. Branzell</i>		Address <i>(2)</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Vascular Accident</i> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Generalized Arteriosclerosis</i> DUE TO (c) <i>hypertension</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Pulmonary Emphysema & arteriosclerotic CVD</i>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>5-14-59</i> to <i>5-15-59</i> , that I last saw the deceased alive on <i>5-14-59</i> , 19 <i>59</i> , and that death occurred at <i>1:59</i> P. M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Frank M Shipley</i>		ADDRESS (Street, city or town, state) <i>121 Cathedral St 5-15-59</i>	
PHYSICIAN'S NAME (Type) <i>Frank M Shipley</i>		DATE SIGNED <i>5-15-59</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<i>Burial</i>	<i>5-16-59</i>	<i>Cedar Bluff</i>	<i>Annapolis Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Taylor Sons</i>		ADDRESS <i>Annapolis Md.</i>	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
DATE <i>MAY 18 '59</i>		<i>Arthur S. Kneel</i>	

death: Page 4

funeral director, Pages 1 and 2, and in any event within 72 hours after death.

THE ATTENDING PHYSICIAN: The law requires that the death be certified by the attending physician and completely filled in by the attending physician and completely filled in by the attending physician and completely filled in by the attending physician.

OR: After this certificate has been signed by the attending physician and completely filled in by the attending physician and completely filled in by the attending physician.

attached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, and in any event within 72 hours after death.

prior to burial, cremation, or removal, and in any event within 72 hours after death.

05003

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 18

CERTIFICATE OF DEATH

1003

Last Date of

FEDERAL BUREAU OF INVESTIGATION

HOSPITAL

PLACE OF BIRTH

1. Name of deceased (Print or write full name, including middle name or initial, and surname)

2. Date of birth (Print or write full date, including month and year)

3. Sex (Print or write male or female)

4. Race (Print or write race)

5. Usual residence (Print or write full address, including street, city, county, and state)

6. Date of death (Print or write full date, including month and year)

7. Place of death (Print or write full address, including street, city, county, and state)

8. Cause of death (Print or write full cause of death, including immediate and underlying causes)

9. Manner of death (Print or write manner of death, including natural, accidental, suicide, homicide, or undetermined)

10. Signature of physician (Print or write full name, including middle name or initial, and surname)

11. Signature of medical examiner (Print or write full name, including middle name or initial, and surname)

12. Signature of coroner (Print or write full name, including middle name or initial, and surname)

13. Signature of registrar (Print or write full name, including middle name or initial, and surname)

14. Signature of clerk (Print or write full name, including middle name or initial, and surname)

15. Signature of auditor (Print or write full name, including middle name or initial, and surname)

16. Signature of treasurer (Print or write full name, including middle name or initial, and surname)

17. Signature of controller (Print or write full name, including middle name or initial, and surname)

18. Signature of secretary (Print or write full name, including middle name or initial, and surname)

19. Signature of assistant secretary (Print or write full name, including middle name or initial, and surname)

20. Signature of stenographer (Print or write full name, including middle name or initial, and surname)

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5110

CERTIFICATE OF DEATH

Reg. Dist. No. **05072**

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville			c. LENGTH OF STAY IN 1b 4 mo. 9 da.			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3V01-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital				d. STREET ADDRESS 1709 W. Lexington Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Lonnie Middle Last Brooks		4. DATE OF DEATH Month 5 Day 24 Year 1959					
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-15-1878	9. AGE (In years last birthday) 80 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown			14. MOTHER'S MAIDEN NAME Unknown				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. -		INFORMANT Hospital Record		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart Failure 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Heart Disease DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. - - 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -		20f. (City or town) (County) (State) - - -	
21. I certify that I attended the deceased from 1/15, 1959 , to 5/24, 1959 , that I last saw the deceased alive on 5/24, 1959 and that death occurred at 4:55P M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>[Signature]</i>		ADDRESS (Street, city or town, state) DATE SIGNED Crownsville State Hospital, Md. 6/4/59					
PHYSICIAN'S NAME (Type) L. Benedict, M.D.		Crownsville State Hospital, Md. 6/4/59					
22a. BURIAL, CREMATION, REMOVAL (Specify) General		22b. DATE THEREOF 6/4/59		22c. NAME OF CEMETERY OR CREMATORY of Md. Med. School		22d. LOCATION (City, town, or county) (State) Baltimore Md.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>[Signature]</i>				ADDRESS		24a. REC'D BY REGISTRAR DATE JUN 5 '59	
				24b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

00078

CERTIFICATE OF DEATH

1110

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05073

5076 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Ad County</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Ad County</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis Md.</u>		c. LENGTH OF STAY IN 1b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis Md.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Ad General Hosp.</u>		d. STREET ADDRESS <u>199 Clay Street.</u>	
3. NAME OF DECEASED (Type or print) <u>Charles</u> First <u>Richard</u> Middle <u>Brown</u> Last		4. DATE OF DEATH Month <u>5</u> - Day <u>31</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-29-1890</u>
9. AGE (In years last birthday) <u>69</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Naval Hosp.</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Richard Brown</u>		14. MOTHER'S MAIDEN NAME <u>Nancy Jenkins</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Louise H. Brown - Anna. Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertension of both lungs</u> <u>180X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>May 31, 1958</u> to <u>May 31, 1959</u> , that I last saw the deceased alive on <u>May 31, 1959</u> , and that death occurred at <u>8:30 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>R. L. Richardson</u> M.D.		ADDRESS (Street, city or town, state) <u>110 Clay St.,</u> DATE SIGNED <u>6/2/59</u>	
PHYSICIAN'S NAME (Type) <u>R. L. Richardson</u>		<u>Annapolis, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>6-4-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Brewer Hill</u>	22d. LOCATION (City, town, or county) (State) <u>Annapolis Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Keese #1, 108 Wash. St. Annapolis</u>		ADDRESS	
24a. REC'D BY REGISTRAR <u>3</u> DATE <u>6/3/59</u>		24b. REGISTRAR'S SIGNATURE <u>Christina E. Keese</u>	

65073

CERTIFICATE OF DEATH

2056

See Form No.

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH		6. OCCUPATION		7. MARITAL STATUS		8. COLOR		9. RELIGION		10. EDUCATION		11. SOCIAL CLASS		12. PLACE OF DEATH		13. DATE OF DEATH		14. TIME OF DEATH		15. CAUSE OF DEATH		16. MANNER OF DEATH		17. SIGNATURE OF PHYSICIAN		18. SIGNATURE OF REGISTRAR		19. SIGNATURE OF WITNESSES		20. SIGNATURE OF DECEASED	
JAMES J. JONES		M		45		10/10/1870		NEW YORK		LABORER		MARRIED		WHITE		CATHOLIC		HIGH SCHOOL		MIDDLE CLASS		NEW YORK		10/10/1915		10:00 AM		HEART DISEASE		NATURAL		J. J. JONES		J. J. JONES		J. J. JONES			
21. FULLY CERTIFIED BY PHYSICIAN		22. FULLY CERTIFIED BY REGISTRAR		23. FULLY CERTIFIED BY WITNESSES		24. FULLY CERTIFIED BY DECEASED		25. FULLY CERTIFIED BY PHYSICIAN		26. FULLY CERTIFIED BY REGISTRAR		27. FULLY CERTIFIED BY WITNESSES		28. FULLY CERTIFIED BY DECEASED		29. FULLY CERTIFIED BY PHYSICIAN		30. FULLY CERTIFIED BY REGISTRAR		31. FULLY CERTIFIED BY WITNESSES		32. FULLY CERTIFIED BY DECEASED		33. FULLY CERTIFIED BY PHYSICIAN		34. FULLY CERTIFIED BY REGISTRAR		35. FULLY CERTIFIED BY WITNESSES		36. FULLY CERTIFIED BY DECEASED		37. FULLY CERTIFIED BY PHYSICIAN		38. FULLY CERTIFIED BY REGISTRAR		39. FULLY CERTIFIED BY WITNESSES		40. FULLY CERTIFIED BY DECEASED	

1

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BATHING, 18

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5077 CERTIFICATE OF DEATH

Reg. Dist. No.

05074

1. PLACE OF DEATH a. COUNTY <u>A. A</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>A. A</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severna Park</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U. S. General</u>		d. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) First <u>Henry</u> Middle <u>C.</u> Last <u>Campbell</u>		4. DATE OF DEATH Month <u>May</u> Day <u>19</u> Year <u>59</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar. 20 1904</u>
9. AGE (In years last birthday) <u>55</u> yrs.		10. IF UNDER 1 YEAR: IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Air Plains</u>	
11. BIRTHPLACE (State or foreign country) <u>Roanoke Va</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>	
13. FATHER'S NAME <u>John Henry Campbell</u>		14. MOTHER'S MAIDEN NAME <u>Loma T. Hiner</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Frank Campbell</u>		Address <u>300 W. Bay Road Ocean City, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Pulmonary Edema</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Portner Myocardial infarction</u> DUE TO (c) <u>Hypertension</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 hr.</u> <u>3 hr.</u> <u>7 hr.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>5-19-59</u> , 19 <u>59</u> , to <u>5-19-59</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>5-19-59</u> , 19 <u>59</u> , and that death occurred at <u>1059</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Frank M. Shipley</u> M.D.		ADDRESS (Street, city or town, state) <u>121 Cathedral St</u> DATE SIGNED <u>5-20-59</u>	
PHYSICIAN'S NAME (Type) <u>Frank M. Shipley</u>		<u>Annapolis, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 23-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Farrview Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Roanoke Va</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor Sons</u>		ADDRESS <u>Annapolis Md</u>	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	
DATE <u>MAY 22 '59</u>			

CERTIFICATE OF DEATH

5073

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>		4. DATE OF BIRTH <i>Jan 15 1910</i>		5. PLACE OF BIRTH <i>Baltimore, Md</i>	
6. OCCUPATION <i>Teacher</i>		7. MARITAL STATUS <i>Married</i>		8. DATE OF MARRIAGE <i>June 10 1935</i>		9. PLACE OF MARRIAGE <i>Baltimore, Md</i>		10. NAME OF SPOUSE <i>Jane Doe</i>	
11. CAUSE OF DEATH <i>Heart Disease</i>		12. MANNER OF DEATH <i>Natural</i>		13. DATE OF DEATH <i>Dec 10 1955</i>		14. PLACE OF DEATH <i>Home</i>		15. SIGNATURE OF DECEASED <i>John Doe</i>	
16. SIGNATURE OF PHYSICIAN <i>Dr. J. Smith</i>		17. SIGNATURE OF WITNESS <i>John Doe</i>		18. SIGNATURE OF DECEASED <i>John Doe</i>		19. SIGNATURE OF SPOUSE <i>Jane Doe</i>		20. SIGNATURE OF CHILD <i>John Doe</i>	

1. This certificate is to be filled out by the physician or other person who has attended the deceased.

2. The cause of death should be stated in full, and the manner of death should be stated as natural, accidental, or homicidal.

3. The date of death should be stated in full, and the place of death should be stated as home, hospital, or elsewhere.

4. The signature of the deceased should be written in the space provided, if the deceased is able to sign.

5. The signature of the spouse should be written in the space provided, if the spouse is able to sign.

6. The signature of the child should be written in the space provided, if the child is able to sign.

7. The signature of the physician should be written in the space provided, and the signature of the witness should be written in the space provided.

8. The signature of the deceased, spouse, and child should be written in the spaces provided, if they are able to sign.

9. The signature of the physician and witness should be written in the spaces provided.

10. The signature of the deceased, spouse, and child should be written in the spaces provided, if they are able to sign.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

Item 2 Film 243, 8-9-59 as Items 8, 9 Film G242 5-11-59 et

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 05075

1. PLACE OF DEATH o. COUNTY <u>Anne Arundel</u> <u>MARYLAND</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u> c. LENGTH OF STAY in 1b <u>10 yrs.</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PLAZA MANOR Home</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> <u>3V01.4</u> d. STREET ADDRESS <u>607 Claymont Avenue</u> <u>Glen Burnie, Md.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Laura Campbell</u> First Middle Last 4. DATE OF DEATH <u>MAY 4 1959</u> Month Day Year				5. SEX <u>Female</u> 6. COLOR OR RACE <u>Colored</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>1855</u> 9. AGE in years (on birthday) <u>107</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>-</u> 11. BIRTHPLACE (State or foreign country) <u>Ardell Co. N.C.</u> 12. CITIZEN OF WHAT COUNTRY? <u>-</u>				13. FATHER'S NAME <u>UNKNOWN</u> 14. MOTHER'S MAIDEN NAME <u>Zodie Campbell</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. <u>NONE</u> 17. INFORMANT <u>Henry Campbell - 2017 Bolton St.</u> Address				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized arteriosclerosis</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Senility</u> DUE TO (c) <u>-</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Marked generalized osteoporosis lumbo-sacral spine 9-24-1957</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>9-27-1957</u> , 19 <u> </u> , to <u>5-4-1959</u> , 19 <u> </u> , that I last saw the deceased alive on <u>4-19-1959</u> , 19 <u> </u> , and that death occurred at <u>2:30 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>400 N. Carrollton Ave. Balto. 23, Md</u> DATE SIGNED <u>James M. Pair</u>							
ACTUAL SIGNATURE <u>James M. Pair</u> M.D. <u>400 N. Carrollton Ave. Balto. 23, Md</u>				PHYSICIAN'S NAME (Type) <u>James M. Pair, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>5/7/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt Auburn</u>		22d. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Earle Gilmore</u> ADDRESS <u>519 Moschist</u>				24a. REC'D BY REGISTRAR <u>DATE 5/7/59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

CERTIFICATE OF DEATH

1075

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		COUNTY OF BIRTH		STATE OF BIRTH		CITY OF DEATH		COUNTY OF DEATH		STATE OF DEATH	
JAMES H. HARRIS		45		M		W		1875		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE	
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTY OF DEATH		STATE OF DEATH		CITY OF DEATH		COUNTY OF DEATH		STATE OF DEATH		CITY OF DEATH		COUNTY OF DEATH		STATE OF DEATH	
JAN 10 1918		10:30 AM		HOME		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE	
CAUSE OF DEATH		MANNER OF DEATH		DISEASE		SYMPTOMS		TREATMENT		PREVIOUS ILLNESS		PREVIOUS SURGERY		PREVIOUS TRAUMA		PREVIOUS ACCIDENT		PREVIOUS POISONING		PREVIOUS DRUGS		PREVIOUS ALCOHOL	
HEART DISEASE		SUICIDE		CORONARY ARTERY DISEASE		PAIN IN CHEST		NO		NO		NO		NO		NO		NO		NO		NO	
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTY OF DEATH		STATE OF DEATH		CITY OF DEATH		COUNTY OF DEATH		STATE OF DEATH		CITY OF DEATH		COUNTY OF DEATH		STATE OF DEATH	
JAN 10 1918		10:30 AM		HOME		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE	

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH, AND IS NOT VALID FOR THE PURPOSES OF THE FEDERAL GOVERNMENT.

RECORDED IN THE OFFICE OF THE CLERK OF THE DISTRICT COURT OF BALTIMORE, JAN 10 1918.

CLERK OF THE DISTRICT COURT OF BALTIMORE

CERTIFICATE OF DEATH

Reg. Dist. No.

05076

5078

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 Annapolis</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Anne Arundel General Hospital</u>				d. STREET ADDRESS <u>1 Bay ridge Road</u>			
3. NAME OF DECEASED (Type or print) First <u>Franklin</u> Middle <u>M.</u> Last <u>Casey</u>				4. DATE OF DEATH Month <u>May</u> Day <u>17</u> Year <u>19 59</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 17, 1959</u>	
9. AGE (In years last birthday) yrs. <u>2</u>		IF UNDER 1 YEAR Months <u>2</u> Days <u>2</u> Hours <u>2</u> Min. <u>2</u>		11. BIRTHPLACE (State or foreign country) <u>Annapolis, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY			
13. FATHER'S NAME <u>Franklin McDonald Casey</u>				14. MOTHER'S MAIDEN NAME <u>Grace Emma Quade</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mother</u> Address <u>Bay Ridge Road, Annapolis, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumatury</u> <u>761.5</u> DUE TO <u>Pneumatury</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pre-term rupture Membranes</u> DUE TO (c) <u>Twin pregnancy</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>1st Twin</u>				INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Dec 1958</u> , to <u>May 17, 1959</u> , that I last saw the deceased alive on <u>May 17, 1959</u> , and that death occurred at <u>6:45 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>[Signature]</u> M.D.				ADDRESS (Street, city or town, state) DATE SIGNED			
PHYSICIAN'S NAME (Type) <u>S. M. CHRISTIAN, JR.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5-19-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Wallercrest Kent</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u> ADDRESS <u>Annapolis Md.</u>				24a. REC'D BY REGISTRAR DATE <u>MAY 20 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH	
5. PLACE OF BIRTH		6. OCCUPATION		7. MARITAL STATUS		8. COLOR	
9. DATE OF DEATH		10. TIME OF DEATH		11. PLACE OF DEATH		12. CAUSE OF DEATH	
13. MEDICAL HISTORY		14. PRESENT ILLNESS		15. TREATMENT		16. POST-MORTEM EXAMINATION	
17. SIGNATURE OF PHYSICIAN		18. SIGNATURE OF REGISTRAR		19. SIGNATURE OF WITNESSES		20. SIGNATURE OF DECEASED	

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1

THIS CERTIFICATE IS TO BE FILED IN THE OFFICE OF THE REGISTRAR OF DEATHS, BALTIMORE, MARYLAND, AND IN THE OFFICE OF THE CLERK OF THE DISTRICT COURT, BALTIMORE, MARYLAND, FOR THE PURPOSE OF RECORDING AND STATISTICS.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5112 CERTIFICATE OF DEATH

Reg. Dist. No.

05077

1. PLACE OF DEATH o. COUNTY <u>A. A.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>A. A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gibson Island</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gibson Island</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kerry Beacon Rd.</u>		d. STREET ADDRESS <u>Kerry Beacon Rd.</u>	
3. NAME OF DECEASED (Type or print) <u>FRANK STRADON CHAVANNES</u>		4. DATE OF DEATH Month <u>May</u> Day <u>21</u> Year <u>19 59</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 4, 1870</u>
9. AGE (In years last birthday) <u>88</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Insurance</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Kingston, Jamaica</u>	
11. BIRTHPLACE (State or foreign country) <u>U. S. A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Lino Luciano Chavannes</u>		14. MOTHER'S MAIDEN NAME <u>Henderson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT <u>Mrs. Beatrice M. Chavannes - Kerry Beacon Rd.</u>		Address <u>Gibson Island, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>SACHEXIA</u> <u>177X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>GENERALIZED CARCINOMATOSIS</u> DUE TO (c) <u>CARCINOMA PROSTATE</u>		INTERVAL BETWEEN ONSET AND DEATH <u>30 DAYS</u> <u>2 YRS</u> <u>6 YRS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>ARTERIOSCLEROTIC CARDIO-VASCULAR-RENAL DISEASE</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>MAY 21</u> , 19 <u>59</u> , to <u>MAY 21</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>MAY 21</u> , 19 <u>59</u> , and that death occurred at <u>8:30 P.</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>MOUNTAIN RD.</u> DATE SIGNED ACTUAL SIGNATURE <u>Arthur Lankford Jr.</u> M.D. <u>PASADENA, MARYLAND.</u> PHYSICIAN'S NAME (Type) <u>ARTUR LANKFORD JR.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 25, 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Woodlawn, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Tiekner & Sons - Balt 17</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 25 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur Lankford Jr.</u>			

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED MARY ANN BROWN</p>		<p>2. SEX F</p>		<p>3. AGE 78</p>	
<p>4. DATE OF DEATH 10/15/1968</p>		<p>5. TIME OF DEATH 10:00 AM</p>		<p>6. PLACE OF DEATH HOME</p>	
<p>7. OCCASION OF DEATH OLD AGE</p>		<p>8. CAUSE OF DEATH HEART DISEASE</p>		<p>9. MANNER OF DEATH NATURAL</p>	
<p>10. SIGNATURE OF PHYSICIAN J. B. SMITH</p>		<p>11. SIGNATURE OF DECEASED (None)</p>		<p>12. SIGNATURE OF WITNESSES J. B. SMITH, M.D.</p>	
<p>13. SIGNATURE OF REGISTRAR J. B. SMITH</p>		<p>14. SIGNATURE OF DECEASED (None)</p>		<p>15. SIGNATURE OF WITNESSES J. B. SMITH, M.D.</p>	
<p>16. SIGNATURE OF PHYSICIAN J. B. SMITH</p>		<p>17. SIGNATURE OF DECEASED (None)</p>		<p>18. SIGNATURE OF WITNESSES J. B. SMITH, M.D.</p>	
<p>19. SIGNATURE OF REGISTRAR J. B. SMITH</p>		<p>20. SIGNATURE OF DECEASED (None)</p>		<p>21. SIGNATURE OF WITNESSES J. B. SMITH, M.D.</p>	
<p>22. SIGNATURE OF PHYSICIAN J. B. SMITH</p>		<p>23. SIGNATURE OF DECEASED (None)</p>		<p>24. SIGNATURE OF WITNESSES J. B. SMITH, M.D.</p>	
<p>25. SIGNATURE OF REGISTRAR J. B. SMITH</p>		<p>26. SIGNATURE OF DECEASED (None)</p>		<p>27. SIGNATURE OF WITNESSES J. B. SMITH, M.D.</p>	
<p>28. SIGNATURE OF PHYSICIAN J. B. SMITH</p>		<p>29. SIGNATURE OF DECEASED (None)</p>		<p>30. SIGNATURE OF WITNESSES J. B. SMITH, M.D.</p>	
<p>31. SIGNATURE OF REGISTRAR J. B. SMITH</p>		<p>32. SIGNATURE OF DECEASED (None)</p>		<p>33. SIGNATURE OF WITNESSES J. B. SMITH, M.D.</p>	
<p>34. SIGNATURE OF PHYSICIAN J. B. SMITH</p>		<p>35. SIGNATURE OF DECEASED (None)</p>		<p>36. SIGNATURE OF WITNESSES J. B. SMITH, M.D.</p>	
<p>37. SIGNATURE OF REGISTRAR J. B. SMITH</p>		<p>38. SIGNATURE OF DECEASED (None)</p>		<p>39. SIGNATURE OF WITNESSES J. B. SMITH, M.D.</p>	
<p>40. SIGNATURE OF PHYSICIAN J. B. SMITH</p>		<p>41. SIGNATURE OF DECEASED (None)</p>		<p>42. SIGNATURE OF WITNESSES J. B. SMITH, M.D.</p>	
<p>43. SIGNATURE OF REGISTRAR J. B. SMITH</p>		<p>44. SIGNATURE OF DECEASED (None)</p>		<p>45. SIGNATURE OF WITNESSES J. B. SMITH, M.D.</p>	
<p>46. SIGNATURE OF PHYSICIAN J. B. SMITH</p>		<p>47. SIGNATURE OF DECEASED (None)</p>		<p>48. SIGNATURE OF WITNESSES J. B. SMITH, M.D.</p>	
<p>49. SIGNATURE OF REGISTRAR J. B. SMITH</p>		<p>50. SIGNATURE OF DECEASED (None)</p>		<p>51. SIGNATURE OF WITNESSES J. B. SMITH, M.D.</p>	
<p>52. SIGNATURE OF PHYSICIAN J. B. SMITH</p>		<p>53. SIGNATURE OF DECEASED (None)</p>		<p>54. SIGNATURE OF WITNESSES J. B. SMITH, M.D.</p>	
<p>55. SIGNATURE OF REGISTRAR J. B. SMITH</p>		<p>56. SIGNATURE OF DECEASED (None)</p>		<p>57. SIGNATURE OF WITNESSES J. B. SMITH, M.D.</p>	
<p>58. SIGNATURE OF PHYSICIAN J. B. SMITH</p>		<p>59. SIGNATURE OF DECEASED (None)</p>		<p>60. SIGNATURE OF WITNESSES J. B. SMITH, M.D.</p>	
<p>61. SIGNATURE OF REGISTRAR J. B. SMITH</p>		<p>62. SIGNATURE OF DECEASED (None)</p>		<p>63. SIGNATURE OF WITNESSES J. B. SMITH, M.D.</p>	
<p>64. SIGNATURE OF PHYSICIAN J. B. SMITH</p>		<p>65. SIGNATURE OF DECEASED (None)</p>		<p>66. SIGNATURE OF WITNESSES J. B. SMITH, M.D.</p>	
<p>67. SIGNATURE OF REGISTRAR J. B. SMITH</p>		<p>68. SIGNATURE OF DECEASED (None)</p>		<p>69. SIGNATURE OF WITNESSES J. B. SMITH, M.D.</p>	
<p>70. SIGNATURE OF PHYSICIAN J. B. SMITH</p>		<p>71. SIGNATURE OF DECEASED (None)</p>		<p>72. SIGNATURE OF WITNESSES J. B. SMITH, M.D.</p>	
<p>73. SIGNATURE OF REGISTRAR J. B. SMITH</p>		<p>74. SIGNATURE OF DECEASED (None)</p>		<p>75. SIGNATURE OF WITNESSES J. B. SMITH, M.D.</p>	
<p>76. SIGNATURE OF PHYSICIAN J. B. SMITH</p>		<p>77. SIGNATURE OF DECEASED (None)</p>		<p>78. SIGNATURE OF WITNESSES J. B. SMITH, M.D.</p>	
<p>79. SIGNATURE OF REGISTRAR J. B. SMITH</p>		<p>80. SIGNATURE OF DECEASED (None)</p>		<p>81. SIGNATURE OF WITNESSES J. B. SMITH, M.D.</p>	
<p>82. SIGNATURE OF PHYSICIAN J. B. SMITH</p>		<p>83. SIGNATURE OF DECEASED (None)</p>		<p>84. SIGNATURE OF WITNESSES J. B. SMITH, M.D.</p>	
<p>85. SIGNATURE OF REGISTRAR J. B. SMITH</p>		<p>86. SIGNATURE OF DECEASED (None)</p>		<p>87. SIGNATURE OF WITNESSES J. B. SMITH, M.D.</p>	
<p>88. SIGNATURE OF PHYSICIAN J. B. SMITH</p>		<p>89. SIGNATURE OF DECEASED (None)</p>		<p>90. SIGNATURE OF WITNESSES J. B. SMITH, M.D.</p>	
<p>91. SIGNATURE OF REGISTRAR J. B. SMITH</p>		<p>92. SIGNATURE OF DECEASED (None)</p>		<p>93. SIGNATURE OF WITNESSES J. B. SMITH, M.D.</p>	
<p>94. SIGNATURE OF PHYSICIAN J. B. SMITH</p>		<p>95. SIGNATURE OF DECEASED (None)</p>		<p>96. SIGNATURE OF WITNESSES J. B. SMITH, M.D.</p>	
<p>97. SIGNATURE OF REGISTRAR J. B. SMITH</p>		<p>98. SIGNATURE OF DECEASED (None)</p>		<p>99. SIGNATURE OF WITNESSES J. B. SMITH, M.D.</p>	
<p>100. SIGNATURE OF PHYSICIAN J. B. SMITH</p>		<p>101. SIGNATURE OF DECEASED (None)</p>		<p>102. SIGNATURE OF WITNESSES J. B. SMITH, M.D.</p>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Filed 6-2-59 at
5113 CERTIFICATE OF DEATH

05078

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville c. LENGTH OF STAY IN 1b 32 years, 5 mos. Upper Marlboro d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 16 X-2 d. STREET ADDRESS - - - e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Robert		4. DATE OF DEATH Month 5 Day 20 Year 1959	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1878
9. AGE (In years last birthday) 80 1/2 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY - -	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Clark		14. MOTHER'S MAIDEN NAME Susan West	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. - -	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Thrombosis (c) Arteriosclerotic Cardiovascular Disease		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) - - -	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. - - - 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) - - -		20f. (City or town) (County) (State) - - -	
21. I certify that I attended the deceased from 12/9 , 19 26 , to 5/20 , 19 59 , that I last saw the deceased alive on 5/20 , 19 59 , and that death occurred at 2:00 P. M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Crownsville State Hosp., Md. 5/20/59 ACTUAL SIGNATURE Lionel McHenry Mapp, M.D. PHYSICIAN'S NAME (Type) Crownsville State Hosp., Md. 5/20/59			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-25-59	
22c. NAME OF CEMETERY OR CREMATORY St. Cuthbert		(State) Washington D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Rollens Funeral Home		24a. REC'D BY REGISTRAR DATE 2 May 25 '59	
ADDRESS 4334		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

5114 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>A.A.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>A.A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BEST GATE Rd.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL-BEST GATE Rd.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Box 316-B</u>		d. STREET ADDRESS <u>Box 316-B</u>	
3. NAME OF DECEASED (Type or print) <u>RALEIGH AUGUSTUS COVERT</u>		4. DATE OF DEATH <u>5 2 1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-21-1899</u>
9. AGE (In years last birthday) <u>59</u>		10. IF UNDER 1 YEAR <u>39</u> Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CUSTOMER-Bd. of Education</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MANNING S. CAROLINA</u>	
11. BIRTHPLACE (State or foreign country) <u>MANNING S. CAROLINA</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>JOHN B. COVERT</u>		14. MOTHER'S MAIDEN NAME <u>LULA-BENBOW</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>23-36-5814</u>	
17. INFORMANT <u>JUANITA B. COVERT-Box 316-B</u>		Address <u>ANNAPOLIS-MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> <u>493X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>5-5-59</u> , 19 <u>59</u> , to <u>5-7-59</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>5-5-59</u> , 19 <u>59</u> , and that death occurred at <u>M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>A.T. ALLEN</u>		DATE SIGNED <u>5-9-59</u>	
PHYSICIAN'S NAME (Type) <u>A.T. ALLEN</u>		ADDRESS (Street, city or town, state) <u>62 Exchange</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>5-12-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Brewer-Hill</u>	22d. LOCATION (City, town, or county) (State) <u>ANNAPOLIS-MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>CHARLES E. HICKS</u>		24a. REC'D BY REGISTRAR <u>DATE MAY 13 '59</u>	
ADDRESS <u>ANNAPOLIS-MD.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hana</u>	

STATE OF TEXAS
COUNTY OF DALLAS

My name is M. L. [illegible]

and I am the [illegible] of [illegible]

and I am the [illegible] of [illegible]

and I am the [illegible] of [illegible]

and I am the [illegible] of [illegible]

and I am the [illegible] of [illegible]

and I am the [illegible] of [illegible]

and I am the [illegible] of [illegible]

and I am the [illegible] of [illegible]

and I am the [illegible] of [illegible]

and I am the [illegible] of [illegible]

and I am the [illegible] of [illegible]

and I am the [illegible] of [illegible]

and I am the [illegible] of [illegible]

and I am the [illegible] of [illegible]

and I am the [illegible] of [illegible]

and I am the [illegible] of [illegible]

and I am the [illegible] of [illegible]

and I am the [illegible] of [illegible]

and I am the [illegible] of [illegible]

5079 CERTIFICATE OF DEATH

05080

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Q Q</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MD</i> b. COUNTY <i>Q Q</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>24 Spa View Circle</i>		d. STREET ADDRESS <i>24 Spa View Circle</i>	
3. NAME OF DECEASED (Type or print) First <i>L.</i> Middle <i>Albert</i> Last <i>Crandall</i>		4. DATE OF DEATH Month <i>May</i> Day <i>7</i> Year <i>19 59</i>	
5. SEX <i>Male</i>	COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Oct 12-1890</i>
9. AGE (In years last birthday) <i>68</i> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Drug Store Owner</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Druggist</i>	
11. BIRTH PLACE (State or foreign country) <i>Annapolis Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Charles A. Crandall</i>		14. MOTHER'S MAIDEN NAME <i>Elizabeth E. Linderborn</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>Lucian M. Crandall (2)</i>	
17. INFORMANT <i>Lucian M. Crandall</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Coronary Thrombosis - 420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Long Standing Emphysema</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>Sudden</i> <i>Several yrs.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>May 31</i> , 19 <i>57</i> , to <i>May 7</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>May 6</i> , 19 <i>59</i> , and that death occurred at <i>11 P.</i> M., from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>5181 59</i> DATE SIGNED	
ACTUAL SIGNATURE <i>Oliver Purvis</i>		M.D. <i>40 Franklin St Annapolis Md</i>	
PHYSICIAN'S NAME (Type) <i>J. OLIVER PURVIS</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <i>May 11-59</i>	22c. NAME OF CEMETERY OR CREMATORY <i>St Mary's</i>	22d. LOCATION (City, town, or county) (State) <i>Annapolis Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Taylor</i>		24a. REC'D BY REGISTRAR DATE <i>MAY 11 '59</i>	
ADDRESS <i>Annapolis Md.</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hanes</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **05081**

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Anne Arundel 5115 MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Same b. COUNTY Same	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnee		c. LENGTH OF STAY IN 1b 10 m.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 111 Sunset Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Mrs. Emma Reed Crapster		4. DATE OF DEATH May 21st. 19 59	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/3/78
9. AGE (In years last birthday) 80 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired housewife		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William H. W. Reed		14. MOTHER'S MAIDEN NAME Seymour	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. No	
17. INFORMANT Mr. E. R. Crapster (son)		18. ADDRESS 111 Sunset Drive	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) General Artriosclerosis 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined monner <input type="checkbox"/>			
ACTUAL SIGNATURE Gustave H. Faubert M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Gustave H. Faubert, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 5/21/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 5-22, 1959	22c. NAME OF CEMETERY OR CREMATORY Loudon Park	22d. LOCATION (City, town, or county) (State) Baltimore, Md.
23. FUNERAL DIRECTOR'S SIGNATURE G. Edwards Strong		24a. REC'D BY REGISTRAR DATE MAY 22 '59	
24b. REGISTRAR'S SIGNATURE Orin S. Kraus			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5116

CERTIFICATE OF DEATH

Reg. Dist. No.

05082

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY AA			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Odenton				c. LENGTH OF STAY IN 1b 5 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Betson Avenue				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Marion Middle Crosby Last Crosby				4. DATE OF DEATH Month May Day 28 Year 19 59			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> SEPARATED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 10, 1867	
9. AGE (In years last birthday) 92 yrs.		IF UNDER 1 YEAR Months 2 Days 28 Hours 19 Min.		IF UNDER 24 HRS. Months 2 Days 28 Hours 19 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired from Western Electric				10b. KIND OF BUSINESS OR INDUSTRY Maryland		11. BIRTHPLACE (State or foreign country) USA	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME George Crosby				14. MOTHER'S MAIDEN NAME Ann Sligh			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or date of service) none				16. SOCIAL SECURITY NO. 217-22-0257		17. INFORMANT Mrs Myrtle Hoffman, same as 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442X Acute Myocardial Infarction - DUE TO Cardio Vasc. Renal Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral Arteriosclerosis DUE TO Cerebral Arteriosclerosis (c) Cerebral Arteriosclerosis				INTERVAL BETWEEN ONSET AND DEATH 2 days 1 year			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased Oct 15, 1958 to May 31, 1959 , that I last saw the deceased alive May 27, 1959 , and that death occurred May 28, 1959 , from the causes and on the date stated above.							
ACTUAL SIGNATURE DR. JOSEPH LIPSKEY M.D.				DATE SIGNED 5-28-59			
PHYSICIAN'S NAME (Type) DR. JOSEPH LIPSKEY							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 31, 1959		22c. NAME OF CEMETERY OR CREMATORY Nichols Bethel		22d. LOCATION (City, town, or county) (State) Odenton, AA, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Hopping & Kirkley, Glen Burnie, Md.				24a. REC'D BY REGISTRAR DATE May 1 1959		24b. REGISTRAR'S SIGNATURE William S. K...	

9242

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05084

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Same b. COUNTY Same		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Severna Park		c. LENGTH OF STAY IN 1b 18 months.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Same	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) McKinzie Rd.				d. STREET ADDRESS Same	
3. NAME OF DECEASED (Type or print) Clifton Alexander Day Sr.			4. DATE OF DEATH Month May Day 15th. Year 19 59		
5. SEX M	6. COLOR OR RACE C	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/18/19		9. AGE (In years last birthday) 39 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintenance Man at USA Naval Academy		10b. KIND OF BUSINESS OR INDUSTRY Arnold, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Benjamin Day			14. MOTHER'S MAIDEN NAME Louise Day		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) 11 World War		16. SOCIAL SECURITY NO.		17. INFORMANT Address Mrs. Louise Day (mother)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____					INTERVAL BETWEEN ONSET AND DEATH Sudden
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Arnold,	(County) Maryland	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Gustave H. Faubert		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) Gustave H. Faubert, M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		5/15/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 5/19/59	22c. NAME OF CEMETERY OR CREMATORY Mt. Calvary		22d. LOCATION (City, town, or county) (State) Arnold, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE J. B. Johnson, Box 462, Annapolis, Md		24a. REC'D BY REGISTRAR DATE MAY 20 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Hines	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF NEW YORK
DEPARTMENT OF HEALTH

STATE OF NEW YORK
DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

(15015)

NAME OF DECEASED JAMES H. HANCOCK, JR.		AGE 35		SEX Male		RACE White		DATE OF DEATH April 15, 1935		PLACE OF DEATH New York City	
RESIDENCE 1234 Broadway, New York City		OCCUPATION Salesman		EDUCATION High School		MARRIAGE Married		RELIGION Roman Catholic		CAUSE OF DEATH Heart Disease	
MANNER OF DEATH Natural		DISEASE OR INJURY Coronary Artery Disease		SYMPTOMS Chest pain, shortness of breath		TREATMENT Medical		HISTORY No previous illness		FAMILY HISTORY None	
SIGNATURE OF EXAMINER J. H. Smith, M.D.		DATE April 16, 1935		PLACE New York City		COUNTY New York		STATE New York		FEDERAL BUREAU OF INVESTIGATION New York City	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05085

5118

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Howard</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>		c. LENGTH OF STAY IN 1b <u>7 da.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Henryton</u>		13x-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Crownsville State Hospital</u>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Horace</u> Middle <u>W.</u> Last <u>Fender</u>		4. DATE OF DEATH Month <u>5</u> Day <u>18</u> Year <u>19 59</u>		5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-26-1889</u>		9. AGE (In years last birthday) <u>69</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>- - -</u>		11. BIRTHPLACE (State or foreign country) <u>Unknown Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Nathan Fender</u>				14. MOTHER'S MAIDEN NAME <u>Mariah</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>196 - 26-8371</u>		17. INFORMANT <u>Hospital records</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Peritonitis Fibrinopurulent, Acute</u> <u>561.4</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Adynamic Ileus</u> DUE TO (c) <u>Incarcerated Hernia, Peritoneal Sac, Lesser</u>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>- - - - -</u>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>- - - 19</u> p. m. <u>- - -</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>- - - - -</u>		20f. (City or town) (County) (State) <u>- - - - -</u>	
21. I certify that I attended the deceased from <u>5/11</u> , 19 <u>59</u> , to <u>5/18</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>5/18</u> , 19 <u>59</u> , and that death occurred at <u>1:40 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Crownsville State Hosp., Md.</u> DATE SIGNED <u>5/19/59</u>							
ACTUAL SIGNATURE <u>L. Benedict</u>		PHYSICIAN'S NAME (Type) <u>L. Benedict, M.D.</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5-22-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>West Liberty</u>		22d. LOCATION (City, town, or county) (State) <u>Alpha, Howard Co., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur L. Houghton</u>				24a. REC'D BY REGISTRAR DATE <u>MAY 25 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Houghton</u>	

Age group 1950-1959 1960-1969 1970-1979 1980-1989 1990-1999

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5119

CERTIFICATE OF DEATH

05086

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE [Where deceased lived. If institution: Residence before admission] o. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Glen Burnie</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Glen Burnie</u>			
c. LENGTH OF STAY IN 1b <u>12 yrs.</u>				d. STREET ADDRESS <u>Mountain Rd., Pasadena P.O.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Mountain Rd., Pasadena P.O.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>John</u> First <u>Leo</u> Middle <u>Flanigan</u> Last				4. DATE OF DEATH <u>May</u> Month <u>24</u> Day <u>1959</u> Year			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 4, 1891</u>	
9. AGE (In year lost birthday) <u>67</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Contractor - retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Patrick Flanigan</u>				14. MOTHER'S MAIDEN NAME <u>Mary Connor</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <u>Regina F. Shannahan - daughter; Easton, Md.</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u> <u>153.8</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Carcinoma of Colon with metastases</u> DUE TO (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs +</u> <u>1 yr +</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 18</u> , 1959, to <u>May 24</u> , 1959, that I last saw the deceased alive on <u>May 24</u> , 1959, and that death occurred at <u>10:21 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Kathleen H. Lyons</u> M.D.				ADDRESS (Street, city or town, state) <u>Paisley Rd., Gibson Island, Md.</u> DATE SIGNED <u>5/24/59</u>			
PHYSICIAN'S NAME (Type) <u>Kathleen H. Lyons</u>				<u>Paisley Rd., Gibson Island, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 27, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cathedral Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Maryland.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. H. Wears & Son 805 N Calvert St</u> ADDRESS				24a. REC'D BY REGISTRAR <u>DATE MAY 27 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>	

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES H. HARRIS		45		M		W		1878		BALTIMORE, MD.	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		DATE OF DEATH		PLACE OF DEATH	
1234 E. BALTIMORE ST.		LABORER		HEART DISEASE		NATURAL		JULY 15, 1923		BALTIMORE, MD.	
FATHER'S NAME		MOTHER'S NAME		EDUCATION		RELIGION		MARITAL STATUS		SINGLE	
JAMES H. HARRIS		MARY J. HARRIS		8 YEARS		METHODIST		MARRIED		WIDOW	
PREVIOUS ILLNESS		TREATMENT		HISTORY OF DEATH		TESTIMONY		SIGNATURE OF DECEASED		SIGNATURE OF WITNESSES	
NONE		NONE		DECEASED AT HOME		BY PHYSICIAN					
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		DATE OF DEATH		PLACE OF DEATH	
JULY 15, 1923		BALTIMORE, MD.		HEART DISEASE		NATURAL		JULY 15, 1923		BALTIMORE, MD.	
FATHER'S NAME		MOTHER'S NAME		EDUCATION		RELIGION		MARITAL STATUS		SINGLE	
JAMES H. HARRIS		MARY J. HARRIS		8 YEARS		METHODIST		MARRIED		WIDOW	
PREVIOUS ILLNESS		TREATMENT		HISTORY OF DEATH		TESTIMONY		SIGNATURE OF DECEASED		SIGNATURE OF WITNESSES	
NONE		NONE		DECEASED AT HOME		BY PHYSICIAN					
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		DATE OF DEATH		PLACE OF DEATH	
JULY 15, 1923		BALTIMORE, MD.		HEART DISEASE		NATURAL		JULY 15, 1923		BALTIMORE, MD.	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 9 Film G245 6/4/59 cap

Reg. Dist. No.

05087

1. PLACE OF DEATH a. COUNTY Anne Arundel 5120 MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3401-4			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) N.E. Shore Furnace Branch.				d. STREET ADDRESS 1720 McDonough Street			
3. NAME OF DECEASED (Type or print) First WILLIE Middle PAUL Last FREEMAN				4. DATE OF DEATH Month May Day 15 Year 1959			
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 1, 1929	
9. AGE (In years last birthday) 30 yrs.		IF UNDER 1 YEAR Months 29 Days 29 Hours 29 Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore Md	
13. FATHER'S NAME Willie P. Freeman Sr.				14. MOTHER'S MAIDEN NAME Theresa			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO.		17. INFORMANT Theresa Freeman		Address 2647 S. Paer St.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Drowning, Found Drowned. DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Found drowned.			
20c. TIME OF INJURY Found 5:25 p.m.		Month, Day, Year 5/14/59		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Unknown	
20f. (City or town) Found		(County) Anne Arundel		(State) Md.			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input checked="" type="checkbox"/> .							
ACTUAL SIGNATURE Paul F. Guerin				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Paul F. Guerin, M.D.				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/23/59		22c. NAME OF CEMETERY OR CREMATORY Mt Calvary Cem. A.A. County Md.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Milton E. Ellickson				ADDRESS 1129 N. Carroll St		24a. REC'D BY REGISTRAR MAY 25 '59	
				24b. REGISTRAR'S SIGNATURE Arthur J. Thomas			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

67-083

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

For use by

1. Name of deceased (Print or write full name as shown on birth record or other reliable record)

2. Date of death (Print or write full date)

3. Age at death (Print or write full age)

4. Sex (Print or write full sex)

5. Race (Print or write full race)

6. Usual residence (Print or write full address)

7. Date of birth (Print or write full date)

8. Place of birth (Print or write full place)

9. Date of admission to hospital (Print or write full date)

10. Date of death (Print or write full date)

11. Date of burial (Print or write full date)

12. Name of physician (Print or write full name)

13. Name of hospital (Print or write full name)

14. Name of funeral home (Print or write full name)

15. Name of undertaker (Print or write full name)

16. Name of informant (Print or write full name)

17. Name of witness (Print or write full name)

18. Name of witness (Print or write full name)

19. Name of witness (Print or write full name)

20. Name of witness (Print or write full name)

21. Name of witness (Print or write full name)

22. Name of witness (Print or write full name)

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113. Name of witness (Print or write full name)

114. Name of witness (Print or write full name)

115. Name of witness (Print or write full name)

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 05088

1. PLACE OF DEATH a. COUNTY Anne Arundel		5121		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Same COUNTY Same	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) P.O. Pasadena		c. LENGTH OF STAY IN 1b Over 3 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Same	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Creek Drive, Rock Hill Beach				d. STREET ADDRESS Same	
3. NAME OF DECEASED (Type or print) Mrs. Naomi P. Gabe		First Middle Last		4. DATE OF DEATH Month May Day 8th. Year 19 59	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/16/10		9. AGE (In years last birthday) 48 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia	
13. FATHER'S NAME Robert Lee Pitts		14. MOTHER'S MAIDEN NAME Elizabeth Collison			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220-18-9068		17. INFORMANT George Gabe	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Barbiturates Poisoning, 5.49 (suicide) 970.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH Sudden					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Patient took voluntarily an excessive dose of Nembutal.			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Gustave H. Faubert		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Gustave H. Faubert, M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 5/8/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-11-59		22c. NAME OF CEMETERY OR CREMATORY Glen Haven Cem	
23. FUNERAL DIRECTOR'S SIGNATURE McCully Funeral Home		ADDRESS 130 E. FORT AVE - Balto, Md.		24a. REC'D BY REGISTRAR DATE MAY 12 '59	
				24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be filed with the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5080 CERTIFICATE OF DEATH

Reg. Dist. No. 05089

1. PLACE OF DEATH a. COUNTY <u>A. A.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>A. A.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Linstead on the Severn</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Annapolis General Hosp.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>EVELYN</u> Middle <u>B.</u> Last <u>GERMAN</u>				4. DATE OF DEATH Month <u>May</u> Day <u>1</u> Year <u>1959</u>			
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 6, 1915</u>		9. AGE (In years last birthday) <u>43</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>William H. Butler</u>				14. MOTHER'S MAIDEN NAME <u>Helen E. (unknown)</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		INFORMANT Address <u>Mr. Sheldon G. German - Linstead on the Severn</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 Aortic coronary occlusion</u> DUE TO (b) <u>Coronary atherosclerosis</u> DUE TO (c) <u>?</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <u>3-4 hr.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypothyroidism + hypochloremia</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>February, 1959</u> , to <u>May 1, 1959</u> , that I last saw the deceased alive on <u>April 18, 1959</u> , and that death occurred at <u>3 A. M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John L. Hildebrand</u> M.D.				ADDRESS (Street, city or town, state) DATE SIGNED <u>121 Calverton</u> <u>5/1/59</u>			
PHYSICIAN'S NAME (Type) <u>Annapolis, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/4/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Lickner & Sons - Balto.</u>				24a. REC'D BY REGISTRAR DATE <u>MAY 4 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	

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• **Stress** – the body's response to any demand or challenge.

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 05090

FOR STATE HEALTH DEPT.

Item 18 Film 24 6-19-59 amb

5122

1. PLACE OF DEATH COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Same b. COUNTY Same	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Severn	c. LENGTH OF STAY IN 1b 7 years	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Same	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 222A Quesentown Rd.		d. STREET ADDRESS Same	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) James Edward Gibbs	4. DATE OF DEATH Month May Day 10th. Year 1959		
5. SEX M	6. COLOR OR RACE C	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/3/17
9. AGE (In years last birthday) 41 yrs.		IF UNDER 1 YEAR Months 41 Days 0 Hours 0 Min. 0	IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shipping Clerk		10b. KIND OF BUSINESS OR INDUSTRY Florence S.C.	
11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Addie Gibbs		14. MOTHER'S MAIDEN NAME Mary Davis	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. 200-18-6704	17. INFORMANT Mrs. Cleo Gibbs (mother)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Asthmatic bronchitis 501X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 501X DUE TO (c) 501X			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 501X			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Wm. Updegraff		DATE SIGNED 5/11/59	
EXAMINER'S NAME (Type) Wm. Updegraff		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 5/17/59	22c. NAME OF CEMETERY OR CREMATORY 918 David Hill A/c	22d. LOCATION (City, town, or county) (State) Florence S.C.
23. FUNERAL DIRECTOR'S SIGNATURE G. H. [Signature]		24a. REC'D BY REGISTRAR DATE MAY 12 '59	24b. REGISTRAR'S SIGNATURE Arthur L. [Signature]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be furnished to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5081 CERTIFICATE OF DEATH

Reg. Dist. No. 05091

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ANNE ARUNDEL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>		c. LENGTH OF STAY IN 1b <u>2 DAYS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>ANNE ARUNDEL GEN. HOSP.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>FANNIE</u> Middle <u>GOLDSTEIN</u> Last <u>GOLDSTEIN</u>		4. DATE OF DEATH Month <u>MAY</u> Day <u>3</u> Year <u>1959</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-22-1897</u>
9. AGE (In years last birthday) <u>61</u> yrs.		10. IF UNDER 1 YEAR Months <u>6</u> Days <u>1</u> Hours <u>1</u> Min. <u>0</u>	11. IF UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>New York, N.Y.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Not Known</u>		14. MOTHER'S MAIDEN NAME <u>Not Known</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Morris Goldstein</u> Address <u>102 Sunset Rd</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE RENAL FAILURE due to SHOCK, due to Acute PANCREATITIS, due to Cholangitis</u> DUE TO (b) <u>585X</u> DUE TO (c) <u>3 days</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>			
INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>			
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>5-1-59</u> , to <u>5-3-59</u> , that I last saw the deceased alive on <u>5-3-59</u> , and that death occurred at <u>8:30 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>98 CATHEDRAL ST.</u> DATE SIGNED <u>5-3-59</u> ACTUAL SIGNATURE <u>Jesse L. Wilkins</u> M.D. PHYSICIAN'S NAME (Type) <u>JESSE L. WILKINS, MD, ANNAPOLIS, MARYLAND</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5-4-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Heavening Run</u>		22d. LOCATION (City, town, or county) (State) <u>Barto Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Lewis</u> ADDRESS <u>2100 Eastern Pkwy.</u>		24a. REC'D BY REGISTRAR <u>Arthur L. Kunkin</u> DATE <u>MAY 5 '59</u>	
		24b. REGISTRAR'S SIGNATURE	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
5123 Items 2d & 7 Film G243 5/27/59 cap
CERTIFICATE OF DEATH

Reg. Dist. No. 05092

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CROWNSVILLE		c. LENGTH OF STAY IN 1b 2 yr. 1 mo. 6 da	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION CROWNSVILLE STATE HOSPITAL		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE 3V01-4	
3. NAME OF DECEASED (Type or print) MARY First Middle Last		4. DATE OF DEATH May 9 1959 Month Day Year	
5. SEX F	6. COLOR OR RACE C	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCT. 31, 1865
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) UNKNOWN		9. AGE (In years last birthday) 93 yrs. IF UNDER 1 YEAR Months Days Hours Min.	
10b. KIND OF BUSINESS OR INDUSTRY - - -		11. BIRTHPLACE (State or foreign country) Maryland -	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Richard GOUGH	
14. MOTHER'S MAIDEN NAME Mary		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT Hospital Records Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cancer of pancreas with metastases in the liver 157x. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 15, 1959 , to May 9, 1959 , that I last saw the deceased alive on May 9, 1959 , and that death occurred at 12:20 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Leonardo Garcia		ADDRESS (Street, city or town, state) CROWNSVILLE STATE HOSPITAL DATE SIGNED	
PHYSICIAN'S NAME (Type) LEONARDO GARCIA-BUNUEL		CROWNSVILLE, Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 5/13/59	
22c. NAME OF CEMETERY OR CREMATORY St. Anthony's		22d. LOCATION (City, town, or county) (State) Sedar Hill, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE C.O. Wilson		24a. REC'D BY REGISTRAR 1000 Brantley Ave 24b. REGISTRAR'S SIGNATURE Arthur S. Hume	

2000

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5082 CERTIFICATE OF DEATH

Reg. Dist. No. 05093

1. PLACE OF DEATH a. COUNTY <i>AA</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MD</i> b. COUNTY <i>AA</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>ANNA POLIS</i>				c. LENGTH OF STAY IN 1b <i>YAS</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>316 ADAMS ST</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>10 EASTPORT ANNAPOLIS</i>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				d. STREET ADDRESS <i>1316 ADAMS ST</i>			
3. NAME OF DECEASED (Type or print) First <i>URSULA</i> Middle <i>GRIFFITH</i> Last <i>GRIFITH</i>				4. DATE OF DEATH Month <i>5</i> Day <i>16</i> Year <i>1959</i>			
5. SEX <i>F</i>		6. COLOR OR RACE <i>W</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>FEB 21, 1885</i>	
9. AGE (In years last birthday) <i>74</i> yrs.		IF UNDER 1 YEAR Months <i>7</i> Days <i>16</i> Hours <i>19</i> Min.		IF UNDER 24 HRS. Months <i>7</i> Days <i>16</i> Hours <i>19</i> Min.		12. CITIZEN OF WHAT COUNTRY? <i>MARYLAND</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>—</i>			
11. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>				12. CITIZEN OF WHAT COUNTRY? <i>MARYLAND</i>			
13. FATHER'S NAME <i>Amos Stallings</i>				14. MOTHER'S MAIDEN NAME <i>Susan</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>				16. SOCIAL SECURITY NO. <i>Family</i>			
17. INFORMANT <i>Family</i>				Address <i>Same</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of Breast with generalized metastasis</i> DUE TO <i>metastasis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>—</i> DUE TO <i>—</i> (c) <i>—</i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Oct 10, 1958</i> to <i>5-16-1959</i> that I last saw the deceased alive on <i>5-16-1959</i> and that death occurred at <i>3:30 P.M.</i> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>6 SHAW ST. ANNAPOLIS, MD.</i> DATE SIGNED <i>5/16/59</i>							
ACTUAL SIGNATURE <i>James R. Martin</i> M.D.				PHYSICIAN'S NAME (Type) <i>JAMES R. MARTIN</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>5-20-59</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Baltimore Cem.</i>		22d. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>McCully Funeral Homes</i>				ADDRESS <i>130 E. Fort Ave.</i>		24a. REC'D BY REGISTRAR DATE <i>MAY 20 '59</i>	
24b. REGISTRAR'S SIGNATURE <i>Arthur L. Hines</i>							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5124

CERTIFICATE OF DEATH

05095

Reg. Dist. No. 27

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort George G. Meade, Md</u>				c. LENGTH OF STAY IN 1b <u>13 Months</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U. S. Army Hospital</u>				d. STREET ADDRESS <u>2686 F. McArthur Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Kathryn</u> Middle <u>Butts</u> Last <u>Harrington</u>				4. DATE OF DEATH Month <u>May</u> Day <u>5</u> Year <u>19 59</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Cau</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>29 Dec 1912</u>	
9. AGE (In years last birthday) <u>46</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u> </u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Benjamin H. Butts</u>				14. MOTHER'S MAIDEN NAME <u>Maude Robinson Butts</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>229-22-4714</u>		17. INFORMANT <u>Commander William Forrest Harrington, FGGM, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 Coronary artery Thrombosis, Fresh, left circumflex</u> DUE TO (b) <u> </u> DUE TO (c) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>None</u>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>			
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	
20f. (City or town) <u> </u>				20g. (County) <u> </u>		20h. (State) <u> </u>	
21. I certify that I attended the deceased from <u>0020 5 May, 19 59</u> , to <u>0020 5 May, 19 59</u> , that I last saw the deceased alive on <u>DOA 5 May, 19 59</u> , and that death occurred at <u>0020</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u> </u> DATE SIGNED <u>5 May 1959</u>							
ACTUAL SIGNATURE <u>Leon E. Kassel</u> M.D. <u>U. S. ARMY HOSPITAL</u>							
PHYSICIAN'S NAME (Type) <u>LEON E. KASSEL, MD</u> <u>Fort George G. Meade, Maryland</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>		22b. DATE THEREOF <u>5-6-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Norfolk Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Norfolk, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Cook, Inc., 1217 St. Paul Street</u>				24a. REC'D BY REGISTRAR <u>MAY 7 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

05096

MEDICAL CERTIFICATION

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MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

1902 CERTIFICATE OF DEATH

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5125 CERTIFICATE OF DEATH

05097

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>CALVERT</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GLEN BURNE</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SOLOMONS</u> 04X-2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First Middle Last <u>LEON K. HAYDEN</u>				4. DATE OF DEATH Month Day Year <u>MAY 24 1959</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 28, 1896</u>		9. AGE (In years last birthday) <u>62</u> yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Owner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Restaurant</u>		11. BIRTHPLACE (State or foreign country) <u>St. Mary's Co.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Richard J. Hayden</u>				14. MOTHER'S MAIDEN NAME <u>Susannah E. Higgs</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>WW-1 218-14-3546</u>		17. INFORMANT <u>William Hayden - Glen Burnie, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ARTERIOSCLEROTIC CARDIO VASCULAR DISEASE</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CARDIAL DECOMPENSATION</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April 18, 1958</u> , to <u>MAY 24, 1959</u> , that I last saw the deceased alive on <u>MAY 23, 1959</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Bryant L. Jones</u>				ADDRESS (Street, city or town, state) <u>BRYANT L. JONES, M.D.</u> <u>101 Green Inghway, South</u> <u>Glen Burnie, Maryland</u> <u>Phone: SO 6-3230</u>			
PHYSICIAN'S NAME (Type) <u>BRYANT H. JONES</u>				DATE SIGNED <u>5/25/59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 27, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Middleham Chapel</u>		22d. LOCATION (City, town, or county) (State) <u>Lusby - Calvert Co. - Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>A. O. Harkness & Son - Mutual, Ind</u>				24a. REC'D BY REGISTRAR DATE <u>MAY 27 1959</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 11 Film 242 5-20-59 et

CERTIFICATE OF DEATH

05098

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville State Hosp</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge, Maryland</u>									
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Crownsville State Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First <u>Irene</u> Middle <u>S</u> Last <u>Henry</u>		4. DATE OF DEATH Month <u>May</u> Day <u>3</u> Year <u>1959</u>									
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 6, 1894</u>								
9. AGE (In years last birthday) <u>64</u> yrs. <table border="1"> <tr> <td>IF UNDER 1 YEAR</td> <td>IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> </tr> <tr> <td></td> <td>Hours</td> </tr> <tr> <td></td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR	IF UNDER 24 HRS.	Months	Days		Hours		Min.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic worker</u>	
IF UNDER 1 YEAR	IF UNDER 24 HRS.										
Months	Days										
	Hours										
	Min.										
10b. KIND OF BUSINESS OR INDUSTRY <u>private employment</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>									
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>UNKNOWN</u>									
14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>									
16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <u>Hosp. Records</u>									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular Accident - Embolus</u> DUE TO <u>331x</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Venostasis & Atrial Fibrillation</u> DUE TO <u>331x</u> (c) <u>Ex</u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Ex of surgical neck of of humerus</u>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH									
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Traumatic</u>		20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>4-8</u> - <u>1959</u> p. m.									
20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Crownsville State Hosp, Crownsville, Md</u>									
20f. (City or town) <u>Crownsville, Md</u>		20g. (County) <u>Dorchester Co, Md</u>									
20h. (State) <u>Md</u>		21. I certify that I attended the deceased from <u>Jan 2</u> , 19 <u>59</u> , to <u>May 3</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>May 3, 1959</u> , 19 <u>59</u> , and that death occurred at <u>12:15 PM</u> from the causes and on the date stated above.									
ACTUAL SIGNATURE <u>Leon W. White, MD</u> M.D.		ADDRESS (Street, city or town, state)									
PHYSICIAN'S NAME (Type) <u>Leon W. White, MD</u>		DATE SIGNED									
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>577159</u>		22b. DATE THEREOF <u>577159</u>									
22c. NAME OF CEMETERY OR CREMATORY <u>Hammoville Md</u>		22d. LOCATION (City, town, or county) (State) <u>Dorchester Co, Md</u>									
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leon W. White, MD</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 6 '59</u>									
24b. REGISTRAR'S SIGNATURE <u>Arthur & Emma</u>											

5127

CERTIFICATE OF DEATH

Reg. Dist. No.

05099

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>				c. LENGTH OF STAY IN 1b <u>seven days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severna Park</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Plaza Manor Nursing Home</u>				d. STREET ADDRESS _____			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Henry</u> Middle <u>R.</u> Last <u>Holder</u>				4. DATE OF DEATH Month <u>5</u> - Day <u>27</u> - Year <u>1959</u>			
5. SEX <u>M.</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-27-02</u>	9. AGE (In years last birthday) <u>56</u> yrs.	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>Merchant Marine Cook</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>?</u>		11. BIRTHPLACE (State or foreign country) <u>Antigua Island</u>		12. CITIZEN OF WHAT COUNTRY? <u>B.W.I.</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>?</u> (If yes, give year or dates of service) <u>?</u>		16. SOCIAL SECURITY NO. <u>?</u>		17. INFORMANT <u>Pearl Holder</u> Address <u>1101 E. 20th Street Balt.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis - Metastasis -</u> <u>163X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cancer of Right Lung -</u> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>?</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____					
20c. TIME OF INJURY Hour _____ o. m. _____ p. m. _____ Month _____ Day _____ Year <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from <u>5-20</u> , 19 <u>59</u> , to <u>5-27</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>5-27</u> , 19 <u>59</u> , and that death occurred at <u>11 P.</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Felix Greener</u> M.D.				ADDRESS (Street, city or town, state) <u>P.O. Box 37</u>		DATE SIGNED <u>5/25/59</u>	
PHYSICIAN'S NAME (Type) <u>Felix Greener</u>				Odeution Incl. -			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>6-1-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Auburn Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles R. Law</u> ADDRESS <u>802 Madison Avenue</u>				24a. REC'D BY REGISTRAR DATE <u>JUN 2 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1937

1937

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH	
JAMES EARL RAY		MALE		35		JAN 5 1902		MEMPHIS		TENNESSEE		UNITED STATES		UNITED STATES	
RACE		COLOR		RELIGION		EDUCATION		OCCUPATION		MANNER OF DEATH		CAUSE OF DEATH		DISEASE OR INJURY	
WHITE		WHITE		METHODIST		HIGH SCHOOL		LABORER		SUICIDE		FIRE		FIRE	
PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		TIME OF DEATH		HOUR OF DEATH		MINUTE OF DEATH	
BALTIMORE		BALTIMORE		MARYLAND		UNITED STATES		APR 4 1968		10:00 PM		10:00 PM		10:00 PM	
PLACE OF INTERMENT		CITY OF INTERMENT		STATE OF INTERMENT		COUNTRY OF INTERMENT		DATE OF INTERMENT		TIME OF INTERMENT		HOUR OF INTERMENT		MINUTE OF INTERMENT	
BALTIMORE		BALTIMORE		MARYLAND		UNITED STATES		APR 4 1968		10:00 PM		10:00 PM		10:00 PM	
NAME OF PHYSICIAN		NAME OF SURGEON		NAME OF PATHOLOGIST		NAME OF FORENSIC EXAMINER		NAME OF CORONER		NAME OF JURY		NAME OF JUDGE		NAME OF CLERK	
DR. JAMES EARL RAY		DR. JAMES EARL RAY		DR. JAMES EARL RAY		DR. JAMES EARL RAY		DR. JAMES EARL RAY		DR. JAMES EARL RAY		DR. JAMES EARL RAY		DR. JAMES EARL RAY	
SIGNATURE OF PHYSICIAN		SIGNATURE OF SURGEON		SIGNATURE OF PATHOLOGIST		SIGNATURE OF FORENSIC EXAMINER		SIGNATURE OF CORONER		SIGNATURE OF JURY		SIGNATURE OF JUDGE		SIGNATURE OF CLERK	
JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	
APR 4 1968		APR 4 1968		APR 4 1968		APR 4 1968		APR 4 1968		APR 4 1968		APR 4 1968		APR 4 1968	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5085 CERTIFICATE OF DEATH

Reg. Dist. No. **05100**

1. PLACE OF DEATH a. COUNTY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. LENGTH OF STAY IN 1b 10			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				d. STREET ADDRESS 113 Conduit Street			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First LAURA Middle HOLLADAY Last HOLLADAY				4. DATE OF DEATH Month MAY Day 22 Year 1959			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 22, 1889	
9. AGE (In years last birthday) 69 yrs.		IF UNDER 1 YEAR Months 69 Days 69 Hours 69 Min. 69		IF UNDER 24 HRS. Months 69 Days 69 Hours 69 Min. 69			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) McGregor, Iowa	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME William A. Hall				14. MOTHER'S MAIDEN NAME Eliza Downton			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) ---				16. SOCIAL SECURITY NO. ---			
17. INFORMANT Mrs. William Darkey-Daughter- same as # 2				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 199.2 Calcenous Vosis DUE TO Renal failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Renal failure DUE TO (c) Renal failure							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 199.2							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 5/1, 1959 to 5/22, 1959 , that I last saw the deceased alive on 5/21, 1959 , and that death occurred at 12:55 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 69 Franklin Street, Annapolis, Maryland DATE SIGNED Stewart Christilf							
ACTUAL SIGNATURE Stewart Christilf M.D.							
PHYSICIAN'S NAME (Type) Stewart Christilf MD 69 Franklin Street, Annapolis, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF May 25, 1959			
22c. NAME OF CEMETERY OR CREMATORY Hillcrest Memorial Cemetery				22d. LOCATION (City, town, or county) (State) Annapolis, Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE Hopping Funeral Home				ADDRESS Annapolis, Maryland			
24a. REC'D BY REGISTRAR MAY 26 '59				24b. REGISTRAR'S SIGNATURE Arthur S. Hines			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

05100

1. Name of Deceased: *John Doe*
2. Sex: *Male*
3. Age: *65*
4. Date of Birth: *Jan 1, 1900*
5. Date of Death: *Dec 1, 1965*
6. Place of Death: *Home*
7. Cause of Death: *Heart Disease*
8. Duration of Illness: *2 weeks*
9. Attending Physician: *Dr. J. Smith*
10. Burial Place: *Catholic Cemetery*

11. Signature of Physician: *[Signature]*
12. Signature of Registrar: *[Signature]*
13. Date of Registration: *Dec 5, 1965*
14. Office of Registrar: *Baltimore, Md.*

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05101
Reg. Dist. No.

1
FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Anne Arundel 5128 b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Odenton		c. LENGTH OF STAY IN 1b Life		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Same b. COUNTY Same c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Same	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 209 Valley King Malcom Ave.			d. STREET ADDRESS Same		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) James C. Hutton		4. DATE OF DEATH Month May Day 31st. Year 19 59			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/23/56		9. AGE (In years last birthday) 2 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Fort Meade Hosp. Md.	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Thomas F. Hutton			14. MOTHER'S MAIDEN NAME Kazuko Watanabe		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Parents.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Aspiration of vomitus. 795.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH Sudden
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>Gustave H. Faubert</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) Gustave H. Faubert, M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		5/31/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6/2/59	22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington, Va.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Hopping and Kirkley</i>		ADDRESS Hopping and Kirkley, Glen Burnie, Md.		24a. REC'D BY REGISTRAR JUN 2 59	24b. REGISTRAR'S SIGNATURE <i>Gustave H. Faubert</i>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

10150

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD
MEDICAL EXAMINER'S CERTIFICATE OF DEATHFOR STATE
HEALTH DEPT.

No answer to queries - Code changed from 921.0 to 795.0
7/23/79 - AS

5129

CERTIFICATE OF DEATH

Reg. Dist. No.

05102

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>ANNE ARUNDEL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PASADENA</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PASADENA</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>BEECHWOOD RD. RTE #5</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>JAMES F. JOHNSON</u>				4. DATE OF DEATH <u>5</u> Month <u>28</u> Day <u>1959</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>COLORED</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12/18/84</u>	
9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED LABORER CHEMICAL CO.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>MD</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A</u>	
12. CITIZEN OF WHAT COUNTRY							
13. FATHER'S NAME <u>UNKNOWN</u>				14. MOTHER'S MAIDEN NAME <u>JANE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT <u>VICTORIA JOHNSON - PASADENA MD</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic cardiovascular disease</u> DUE TO (c) <u>Hypertension, essential</u>						INTERVAL BETWEEN ONSET AND DEATH <u>24 hours</u> <u>5 years</u> <u>7 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Prostatectomy - Feb. 1959 for benign Prostatic hypertrophy</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>June 30, 1949</u> , to <u>May 28, 1959</u> , that I last saw the deceased alive on <u>May 28, 1959</u> , and that death occurred at <u>10:35 AM</u> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <u>RFD 8 Box 442 Pasadena, Md.</u> DATE SIGNED <u>May 28, 1959</u>							
ACTUAL SIGNATURE <u>Randall M. McLaughlin</u>				M.D. <u>RFD 8 Box 442 Pasadena, Md.</u>			
PHYSICIAN'S NAME (Type) <u>R.M. McLaughlin</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>5/31/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mc Zion</u>		22d. LOCATION (City, town, or county) (State) <u>Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Marshall P. Hoyer</u>				ADDRESS <u>638 N. Gilmor St</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 1 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05103

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>AA</u> 5086 MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>AA</u>									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN 1b <u>18.75</u>									
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>AA General</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First <u>Woodrow</u> Middle <u>Gerald</u> Last <u>Kirkley</u>		4. DATE OF DEATH Month <u>5</u> Day <u>28</u> Year <u>1959</u>									
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-25-1941</u>								
9. AGE (In years last birthday) <u>18</u> yrs. <table border="1" style="display: inline-table; vertical-align: top;"> <tr> <td colspan="2">IF UNDER 1 YEAR</td> <td colspan="2">IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>School (High)</u>	
IF UNDER 1 YEAR		IF UNDER 24 HRS.									
Months	Days	Hours	Min.								
10b. KIND OF BUSINESS OR INDUSTRY <u>School</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore MD</u>									
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Woodrow W. Kirkley</u>									
14. MOTHER'S MAIDEN NAME <u>Lora May Powell</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>-</u>									
16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>Lora May Tomlinson</u>									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Drowning</u> DUE TO <u>929.8</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <u>Asphyxiation</u> (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>while swimming at Dream's Landing</u>									
20c. TIME OF INJURY Month, Day, Year Hour <u>5</u> a.m. <u>28</u> p.m. <u>1959</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>									
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Swimming Pool</u>		20f. (City or town) <u>AA MD</u>									
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .											
ACTUAL SIGNATURE <u>[Signature]</u>		DATE SIGNED <u>8/28/59</u>									
EXAMINER'S NAME (Type) <u>F. L. Wharff</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-1-1959</u>									
22c. NAME OF CEMETERY OR CREMATORY <u>Calver Hill Cem.</u>		22d. LOCATION (City, town, or county) <u>Anne Arundel Co MD</u>									
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor</u>		24a. REC'D BY REGISTRAR <u>Arthur S. Thomas</u>									
24b. REGISTRAR'S SIGNATURE		DATE <u>JUN 2 '59</u>									

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

5087 CERTIFICATE OF DEATH

05104

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. LENGTH OF STAY IN 1b <u>10 Annapolis</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Anne Arundel General Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Baby boy Marshall B Lake</u>				4. DATE OF DEATH Month Day Year <u>May 5 1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 3, 1959</u>	
9. AGE (In years lost birthday) yrs. <u>2</u>		10. AGE (In years lost birthday) yrs. <u>3</u>		11. BIRTHPLACE (State or foreign country) <u>Annapolis, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>			
13. FATHER'S NAME <u>Charles M. Lake, Jr.</u>				14. MOTHER'S MAIDEN NAME <u>Iris Rawls</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>			
17. INFORMANT <u>Mother</u>				Address <u>21 Eastern Ave., Annapolis, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>776x</u> DUE TO <u>Prematurity</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) _____ DUE TO _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>May 3 1959</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>May 3, 1959</u> , to <u>May 5, 1959</u> , that I last saw the deceased alive on <u>May 5, 1959</u> , and that death occurred at <u>10 A. M.</u> on the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Neil H. Sims</u>				DATE SIGNED <u>5/5/59</u>			
PHYSICIAN'S NAME (Type) <u>NEIL H. SIMS</u>				ADDRESS (Street, city or town, state) <u>95 Cathedral St Annapolis, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>May 8, 1959</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cem.</u>				22d. LOCATION (City, town, or county) (State) <u>Brooklyn, P.D., Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>PK Singleton</u>				ADDRESS <u>Glen Burnie, Md.</u>			
24a. REC'D BY REGISTRAR <u>Arthur S. Hines</u>				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>			
DATE <u>MAY 11 '59</u>							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5088 CERTIFICATE OF DEATH

Reg. Dist. No.

05103

1. PLACE OF DEATH a. COUNTY <u>A.A.</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u> c. LENGTH OF STAY IN 1b <u>2 Days</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>063 Anne Arundel Gen. Hosp</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>A.A.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u> d. STREET ADDRESS <u>11 Parole St</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>CAROLINE ELIZABETH LARKINS</u> First Middle Last 4. DATE OF DEATH <u>5 15 1959</u> Month Day Year		5. SEX <u>F</u> 6. COLOR OR RACE <u>C</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>Sept. 11-1884</u> 9. AGE (In years last birthday) <u>74</u> yrs. 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u> 11. BIRTHPLACE (State or foreign country) <u>A.A. Co. Md.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>WILLIAM PINDELL</u> 14. MOTHER'S MAIDEN NAME <u>CORNELIA OFFER</u> 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> 16. SOCIAL SECURITY NO. <u>NONE</u> 17. INFORMANT <u>GRACE THOMAS-9 Parole St.</u> Address <u>ANNAPOLIS-Md.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis Hypertension Cardiac disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that I attended the deceased from <u>May 10, 1959</u> , to <u>May 14, 1959</u> , that I last saw the deceased alive on <u>May 14, 1959</u> , and that death occurred at <u>12:10 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>110 Cherry St ANNAPOLIS, Md. 5/16/59</u> DATE SIGNED _____ ACTUAL SIGNATURE <u>Dr. Richardson</u> M.D. <u>110 Cherry St ANNAPOLIS, Md. 5/16/59</u> PHYSICIAN'S NAME (Type) _____	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> 22b. DATE THEREOF <u>5-17-59</u> 22c. NAME OF CEMETERY OR CREMATORY <u>Brewer-Hill</u> 22d. LOCATION (City, town, or county) (State) <u>ANNAPOLIS-Md</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles E. Hicks</u> ADDRESS <u>ANNAPOLIS-Md.</u> 24a. REC'D BY REGISTRAR <u>MAY 20 '59</u> DATE <u>MAY 20 '59</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

1. Name of deceased: *William Franklin*

2. Date of death: *April 11, 1941*

3. Place of death: *Home*

4. Cause of death: *Heart failure*

5. Age at death: *68 years*

6. Sex: *Male*

7. Race: *White*

8. Occupation: *Farmer*

9. Marital status: *Married*

10. Signature of physician: *[Signature]*

11. Date of certification: *April 12, 1941*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5089

CERTIFICATE OF DEATH

Reg. Dist. No.

05106

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. LENGTH OF STAY IN 1b <u>X</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel General Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Ida</u> Middle <u>Marie</u> Last <u>Lehr</u>				4. DATE OF DEATH Month <u>May</u> Day <u>30</u> Year <u>1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 22-1980</u>	
9. AGE (In years last birthday) <u>79</u> yrs.		10. UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore-Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework (ret)</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own-home</u>			
13. FATHER'S NAME <u>(Unknown) Bothe</u>				14. MOTHER'S MAIDEN NAME <u>Louise Muhlly</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>NONE</u>			
17. INFORMANT <u>Mrs. Katharine Roessler</u>				Address <u>Rugby Hall Arnold</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic cerebral hemorrhage</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>May 14</u> , 19 <u>59</u> , to <u>May 30</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>May 29</u> , 19 <u>59</u> , and that death occurred at <u>1:30</u> A. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John C. Waldman, M.D.</u>				ADDRESS (Street, city or town, state) <u>121 Cathedral St. Annapolis, Md.</u>			
PHYSICIAN'S NAME (Type) <u>Annapolis, Md.</u>				DATE SIGNED <u>5/30/59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 2, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Brooklyn-R.F.D. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. T. Singleton</u>				ADDRESS <u>Glen Burnie Md</u>		24. REC'D BY REGISTRAR DATE <u>JUN 2 '59</u>	
25. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>							



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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05107

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Anne Arundel 5130 b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Jessup c. LENGTH OF STAY IN lb 3 months d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Maryland House of Correction Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Berlin, Md. b. COUNTY Wicomico Worce. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Berlin, 23X-2 d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Harvey Middle Lee Last Link		4. DATE OF DEATH Month May Day 1 Year 19 59	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/21/30
9. AGE (In years last birthday) 29 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Farm	
11. BIRTHPLACE (State or foreign country) Florida		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Arice (Sonny Boy) Link		14. MOTHER'S MAIDEN NAME Ida Mae McGee	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. (?)	
17. INFORMANT Md. House of Correction Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary thrombo-embolism 465X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus			INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles S. Perry		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Charles S. Perry, M.D.		DATE SIGNED 5/2/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) REMOVED 5-5-59		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY St. Joseph's Cem.		22d. LOCATION (City, town, or county) (State) Florida	
23. FUNERAL DIRECTOR'S SIGNATURE Randolph J. Collick		24a. REC'D BY REGISTRAR 4/2 E. Preston St.	
24b. REGISTRAR'S SIGNATURE Arthur S. Kline		DATE MAY 6 '59	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5131 CERTIFICATE OF DEATH

05108

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Plaza Manor Nursing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mary Middle Elizabeth Last Macer		4. DATE OF DEATH Month May Day 12 Year 1959	
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 2, 1866
9. AGE (In years last birthday) 93 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Corchester Co., Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Harrison Manoco		14. MOTHER'S MAIDEN NAME Leak Manoco	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Golden Macer - 2222 Madison Avenue		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic valvular disease of heart 421.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH over 10 years	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec 7, 1954 to May 12, 1959 , that I last saw the deceased alive on May 12, 1959 , and that death occurred at 2:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE John E. J. Camper M.D.		639 h. Carey Street	
PHYSICIAN'S NAME (Type) JOHN E. J. CAMPER, M.D.		Baltimore Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-17-59	
22c. NAME OF CEMETERY OR CREMATORY Arbutus Memorial Park		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Charles S. Law		24a. REC'D BY REGISTRAR DATE MAY 18 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05109

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>ALLEN</u> 5090 b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u> c. LENGTH OF STAY IN 1b <u>P.O.A.</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>ALLEN</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SHOREHAM BEACH, EDGEWATER</u> d. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) <u>WILLIAM FREDERICK P. MCCONOUGHNEY</u>		4. DATE OF DEATH Month <u>5</u> Day <u>30</u> Year <u>1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1904 AUG 12</u> yrs. <u>54</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ENGINEER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>TELEPHONE CO.</u>	
11. BIRTHPLACE (State or foreign country) <u>OLONI, OHIO</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>PORTER W. MCCONOUGHNEY</u>		14. MOTHER'S MAIDEN NAME <u>ELIZABETH P. DORSEY</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>A</u>	
17. INFORMANT <u>ELIZABETH A. MCCONOUGHNEY, SHOREHAM BEACH</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac disease</u> <u>434.4</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Sudden</u> DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>INTERVAL BETWEEN ONSET AND DEATH</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>E. L. W. HART</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>E. L. W. HART</u>		DATE SIGNED <u>5/30/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/1/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>FT LINCOLN CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>PRINCE GEORGES COUNTY, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur S. Thoms</u>		24a. REC'D BY REGISTRAR <u>DATE JUN 1 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thoms</u>		24c. ADDRESS <u>254 Carroll St NW, D.C.</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

5132

CERTIFICATE OF DEATH

05110

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>AA</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>AA</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Glen Burnie</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>10 OAK Lane</u>				d. STREET ADDRESS <u>1000K Lane</u>			
3. NAME OF DECEASED (Type or print) First <u>CHARA</u> Middle <u>A.</u> Last <u>McCracken</u>				4. DATE OF DEATH Month <u>5-</u> Day <u>11-</u> Year <u>19 59</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 5-1870</u>		9. AGE (In years lost birthday) <u>88</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>No wife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>William Perkins</u>				14. MOTHER'S MAIDEN NAME <u>Sarah E. Christie</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>N</u>		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT Address <u>Mrs Florence Hooper 1000K Lane #68</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Large Bowel</u> 153.7 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <u>Repeating Haemorrhage of Bowel</u> DUE TO (c) <u>10 yr- 9-10 yr-</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>5/11/59</u> , 19 <u>48</u> , to <u>5/11/59</u> , 19 <u>48</u> , that I last saw the deceased alive on <u>5/11/59</u> , 19 <u>48</u> , and that death occurred at <u>12:10 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Chas-L-Ball J.</u> M.D.				ADDRESS (Street, city or town, state) <u>Linthicum, Md.</u>		DATE SIGNED <u>5/11/59</u>	
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5-14-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Loudon PK Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Balto. MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>McCully Funeral Home</u> ADDRESS <u>150 E. Fort Ave</u>				24a. REC'D BY REGISTRAR DATE <u>MAY 14 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

05111

5091

1. PLACE OF DEATH o. COUNTY <u>A.A.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>A.A.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>				c. LENGTH OF STAY IN 1b <u>2 Wks</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>ANNE ARUNDEL Gen.</u>				d. STREET ADDRESS <u>84 College Crk. Terrace</u>			
3. NAME OF DECEASED (Type or print) <u>EMMA-L. Cully-ALIAS-McCully</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>C</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10-6-1881</u>	
9. AGE (In years last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.		10. DATE OF DEATH <u>5 18 19 59</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>			
11. BIRTHPLACE (State or foreign country) <u>Anne Arundel Co, Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>—</u>			
13. FATHER'S NAME <u>UNKNOWN</u>				14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>212-32-3989</u>			
17. INFORMANT <u>Isabella-Thomas; 84 College Crk.</u>				Address <u>ANNAPOLIS MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bilateral Broncho-Pneumonia</u> 501X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>With Right lower lobe Lung Abscess</u> DUE TO <u>Purulent Bronchitis</u> (c) <u>—</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Stenthocharter's Fracture of Rt Femur</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>5/18/59</u> to <u>5/18/59</u> , that I last saw the deceased alive on <u>5/18/59</u> , and that death occurred at <u>11:30 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>[Signature]</u>				M.D. <u>(10-clay ST ANNAPOIS MD)</u>			
PHYSICIAN'S NAME (Type) <u>—</u>				DATE SIGNED <u>5/18/59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>5-21-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>BREWSTER HILL</u>		22d. LOCATION (City, town, or county) (State) <u>ANNAPOLIS - MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles E. Hicks III</u>				24a. REC'D BY REGISTRAR <u>—</u>			
ADDRESS <u>ANNAPOLIS-MD</u>				24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>		DATE <u>MAY 25 '59</u>	

5092 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>A. A.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>A. A.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. LENGTH OF STAY IN 1b <u>X</u> Bay Head			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Annapolis General Hosp.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Claude</u> Middle <u>Ringold</u> Last <u>Milburn</u>				4. DATE OF DEATH Month <u>May</u> Day <u>16</u> Year <u>1959</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 25, 1896</u>	9. AGE (In years lost birthday) <u>62</u> yrs.	IF UNDER 1 YEAR Months <u>62</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>President</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Wilton Hgts. Home Corp.</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>Md.</u>
13. FATHER'S NAME <u>Willard G. Milburn</u>				14. MOTHER'S MAIDEN NAME <u>Carrie -</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>no</u>		INFORMANT <u>Mr. J. Lawrence Iears - 1208 Lake Falls Rd.</u>		Address <u>#10</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute coronary occlusion</u> <u>420.1</u> DUE TO <u>Coronary artery sclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <u>2 yrs</u> (c) <u>2 yrs</u>							INTERVAL BETWEEN ONSET AND DEATH <u>Transit</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from <u>July</u> , 1957, to <u>May</u> , 1959, that I last saw the deceased alive on <u>May 15</u> , 1959, and that death occurred at <u>12:30</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John C. Hedeman</u>		M.D. <u>121 Cathedral</u>		ADDRESS (Street, city or town, state) <u>Annapolis, Md.</u>		DATE SIGNED <u>5/16/59</u>	
PHYSICIAN'S NAME (Type) <u>Annapolis, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>5/19/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn</u>		22d. LOCATION (City, town, or county) <u>Woodlawn, Md.</u>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Dickner & Sons - East</u>				24a. REC'D BY REGISTRAR DATE <u>MAY 19 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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3002 CERTIFICATE OF DEATH

11

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5133

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>GA Co</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>GA Co</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Severn</u>				c. LENGTH OF STAY IN 1b <u>15 yrs</u> x <u>Severn</u> <u>GA Co</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>At home</u>				e. STREET ADDRESS <u>14 Myonard ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Charles</u> First <u>W</u> Middle <u>Millard</u> Last				4. DATE OF DEATH <u>May</u> Month <u>3</u> Day <u>1959</u> Year			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 4-1879</u>	
9. AGE (In years last birthday) <u>79</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Rail Road</u>		11. BIRTHPLACE (State or foreign country) <u>Carmichael Pa</u>	
13. FATHER'S NAME <u>Kenner Millard</u>				14. MOTHER'S MAIDEN NAME <u>Mary Fischer</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>None</u>				16. SOCIAL SECURITY NO. <u>None</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Accident</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>10 years</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____				21. I certify that I attended the deceased from <u>Oct</u> , 19 <u>46</u> , to <u>April 3</u> , 19 <u>59</u> that I last saw the deceased alive on <u>April 2</u> , 19 <u>59</u> , and that death occurred at <u>11:30 AM</u> , from the causes on and on the date stated above.			
ACTUAL SIGNATURE <u>Edmund G. Bennett</u> M.D. <u>Gambrells Rd</u> ADDRESS (Street, city or town, state) <u>5-4-59</u> DATE SIGNED				22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 22b. DATE THEREOF <u>May 6-59</u> 22c. NAME OF CEMETERY OR CREMATORY <u>Eden Haven Cemetery</u> 22d. LOCATION (City, town, or county) <u>Belton Hwy Elba Bm Md</u> (State)			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Bernard G. Frink</u> ADDRESS <u>Elba Bm Md</u> 24a. REC'D BY REGISTRAR <u>MAY 6 '59</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kinn</u>							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

02113

MASSACHUSETTS STATE OF NEW YORK

CENTRAL AIRPORT

2015

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[Faint, mostly illegible text and markings, possibly bleed-through from the reverse side of the page. Some words like "MASSACHUSETTS" and "NEW YORK" are visible.]

1 100 VS A15 (4) 15M 10/57 TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. 1 010 1 100 VS A15 (4) 15M 10/57 TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

5134

CERTIFICATE OF DEATH

Reg. Dist. No.

05114

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN 1b 9Y, 11M, 20D.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		3Y01-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital				d. STREET ADDRESS 937 McDonald Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First George Middle Moody Last Moody				4. DATE OF DEATH Month 5 Day 8 Year 19 59			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11/7/1870	
9. AGE (In years lost birthday) 88 yrs.		IF UNDER 1 YEAR Months 88 Days 8 Hours 19 Min. 59		IF UNDER 24 HRS. Months 88 Days 8 Hours 19 Min. 59			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed				10b. KIND OF BUSINESS OR INDUSTRY - - -		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Gilbert Moody				14. MOTHER'S MAIDEN NAME Elvira Shelton			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unknown		16. SOCIAL SECURITY NO. - - -		17. INFORMANT Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 491X DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Brain Syndrome Associated with Arteriosclerosis 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 5/18/49 , 19 59 , to 5/8 , 19 59 , that I last saw the deceased alive on 5/8 , 19 59 , and that death occurred at 5:00A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Crownsville, Maryland DATE SIGNED 5/12/59							
ACTUAL SIGNATURE L. Benedict, M.D. M.D. Crownsville, Maryland							
PHYSICIAN'S NAME (Type) L. Benedict, M.D. Crownsville State Hosp., Md. 5/12/59							
22a. BURIAL, CREMATION, REMOVAL (Specify) REMOVED		22b. DATE THEREOF 5/12/59		22c. NAME OF CEMETERY OR CREMATORY UNIV. MD. Med. School		22d. LOCATION (City, town, or county) (State) BALTO, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm Reese				24a. REC'D BY REGISTRAR Arthur J. Kraus			
24b. REGISTRAR'S SIGNATURE Arthur J. Kraus				DATE 5/14/59			

1

5135 CERTIFICATE OF DEATH

05115

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Maryland</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>				c. LENGTH OF STAY IN 1b <u>4 yr. 21 da.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Crownsville State Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Nelson</u> Middle <u>Moore</u> Last <u>Moore</u>				4. DATE OF DEATH Month <u>5</u> Day <u>30</u> Year <u>19 59</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>?</u>	
9. AGE (In years last birthday) <u>34</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		11. IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>			
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>- -</u>			
17. INFORMANT <u>Hospital Records</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Aspiration Bronchopneumonia</u> <u>148x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <u>Cancer of Pharynx</u> DUE TO (c) <u> </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> (b) <u> </u> (c) <u> </u> (d) <u> </u> (e) <u> </u> (f) <u> </u> (g) <u> </u> (h) <u> </u> (i) <u> </u> (j) <u> </u> (k) <u> </u> (l) <u> </u> (m) <u> </u> (n) <u> </u> (o) <u> </u> (p) <u> </u> (q) <u> </u> (r) <u> </u> (s) <u> </u> (t) <u> </u> (u) <u> </u> (v) <u> </u> (w) <u> </u> (x) <u> </u> (y) <u> </u> (z) <u> </u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>			
20c. TIME OF INJURY Month <u> </u> Day <u> </u> Year <u>19</u> Hour <u> </u> a. m. <u> </u> p. m. <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>				20f. (City or town) (County) (State) <u> </u>			
21. I certify that I attended the deceased from <u>5/9</u> , 19 <u>55</u> , to <u>5/30</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>5/30</u> , 19 <u>59</u> , and that death occurred at <u>11:50 A</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>L. Benedict</u>				DATE SIGNED <u>6/4/59</u>			
PHYSICIAN'S NAME (Type) <u>L. Benedict, M.D.</u>				ADDRESS (Street, city or town, state) <u>Crownsville State Hospital, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>As above</u>				22b. DATE THEREOF <u>6/4/59</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>U. of Md. Med. School</u>				22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>St. George</u>				ADDRESS <u> </u>			
24a. REC'D BY REGISTRAR <u>JUN 5 '59</u>				24b. REGISTRAR'S SIGNATURE <u>Arthur S. House</u>			

Page 4
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film G242 5-11-59 et

5136

CERTIFICATE OF DEATH

Reg. Dist. No. 05116

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Millersville</u>				c. LENGTH OF STAY IN 1b <u>9 yrs.</u>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Elevator Road - Box 149</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Zenophine F. Moore</u>				4. DATE OF DEATH Month <u>May</u> Day <u>2</u> Year <u>19 59</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 27 - 1861</u> 97 yrs.			
9. AGE (In years last birthday) <u>97</u> yrs.		10. UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		11. BIRTHPLACE (State or foreign country) <u>Wicomico Co - Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Stephen Mills</u>				14. MOTHER'S MAIDEN NAME <u>Mary Ann Mitchell</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>Mrs. Pauline Riley - Same As #12</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>General Arterio Sclerosis</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>								INTERVAL BETWEEN ONSET AND DEATH <u>over 10 years</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)								20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u> </u> <u> </u> <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)				20g. (County)		20h. (State)			
21. I certify that I attended the deceased from <u>January</u> , 19 <u>50</u> , to <u>May 2</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>5/1/59</u> , 19 <u> </u> , and that death occurred at <u>11 P.</u> M., from the causes and on the date stated above.									
ACTUAL SIGNATURE <u>Kustine Parkhurst</u>				ADDRESS (Street, city or town, state) <u>Glen Burnie, Md.</u> DATE SIGNED <u>5/4/59</u>					
PHYSICIAN'S NAME (Type) <u>JOSEPH H. FAUBERT, M.D.</u>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>5/5/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Taylor Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Sharptown - Maryland</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert P. Ware - Glen Burnie</u>				24. REC'D BY REGISTRAR DATE <u>MAY 6 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur & Kenna</u>			

CERTIFICATE OF DEATH

1911

Form with multiple sections for recording death information, including fields for name, age, sex, race, date of death, cause of death, and place of death. The form is divided into several horizontal sections with labels for each field.

PAID

Vertical text on the right margin, possibly a date or reference number.

05117

1. PLACE OF DEATH a. COUNTY Anne Arundel		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ft George G. Meade,		c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Army Hospital				d. STREET ADDRESS 405 4th Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Baby Boy (Not named) Moravitz				4. DATE OF DEATH Month Day Year May 27 1959			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 26 May 1959		9. AGE (In years last birthday) yrs. 13	IF UNDER 1 YEAR Months Days Hours Mins 13 40	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Harvey H. Moravitz				14. MOTHER'S MAIDEN NAME Toyoko Youshikawa			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. -		17. INFORMANT Hospital Records U.S. Army Hospital, Ft George G. Meade, Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity 776X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH 13hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 26 May 1959 , to 27 May 1959 , that I last saw the deceased alive on 26 May 1959 , and that death occurred at 0115 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED U.S. Army Hospital, Ft Meade, Md 27 May 59							
ACTUAL SIGNATURE Myron J. Myers		M.D. U.S. Army Hospital, Ft Meade, Md					
PHYSICIAN'S NAME (Type) Myron J. Myers, MD		U.S. Army Hospital, Ft Meade, Md					
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF MAY 28, 59		22c. NAME OF CEMETERY OR CREMATORY GLEN HAVEN CEMETERY		22d. LOCATION (City, town, or county) (State) GLEN BURNIE, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE HOPPING & KIRKLEY FUNERAL HOME, GLEN BURNIE, Md.				ADDRESS GLEN BURNIE, Md.		24a. REC'D BY REGISTRAR DATE JUN 1 '59	
				24b. REGISTRAR'S SIGNATURE C. S. K.			

2050373xv1

CERTIFICATE OF DEATH

05118

Reg. Dist. No.

5138

1. PLACE OF DEATH a. COUNTY <u>a a</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>AA</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Millersville</u>				c. LENGTH OF STAY IN 1b <u>1 mo</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sanns Nursing Home</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Harry Luden Norris</u>				4. DATE OF DEATH Month Day Year <u>MAY 2 1959</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 25 1895</u>	9. AGE (In years last birthday) <u>64</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Houliington Penna</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Luden Norris</u>				14. MOTHER'S MAIDEN NAME <u>Aune Yocum</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>214-05-0178A</u>		17. INFORMANT <u>Thelma Collison Edgewater Md.</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> <u>493X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cornary artery atherosclerosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. <u>19</u>	Month <u>May</u>	Day <u>1</u>	Year <u>1959</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June</u> 19 <u>57</u> , to <u>May</u> 19 <u>59</u> , that I last saw the deceased alive on <u>May 1</u> 19 <u>59</u> , and that death occurred at <u>7 P</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John L. Hadenman</u> M.D.				ADDRESS (Street, city or town, state) <u>121 Cathedral</u>		DATE SIGNED <u>5/5/59</u>	
PHYSICIAN'S NAME (Type) <u>James J. Hadenman, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>May 4/1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Woodfield</u>		22d. LOCATION (City, town, or county) (State) <u>Edgewater Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Reuben Hardisty</u> ADDRESS <u>Belleville Md</u>				24a. REC'D BY REGISTRAR DATE <u>MAY 12 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Haines</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

5093 CERTIFICATE OF DEATH

05120

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>aa</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>md</i> b. COUNTY <i>aa</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>				c. LENGTH OF STAY IN 1b <i>St Margarets</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>C.C. General Hospt.</i>				d. STREET ADDRESS <i>Hidden Springs</i>			
3. NAME OF DECEASED (Type or print) First <i>William</i> Middle <i>Russell</i> Last <i>Patterson</i>				4. DATE OF DEATH Month <i>5</i> Day <i>25</i> Year <i>1959</i>			
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Apr 16 - 1903</i>	9. AGE (In years lost birthday) <i>36</i> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Washers Dixie</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Mfg Co.</i>		11. BIRTHPLACE (State or foreign country) <i>Baltimore Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>William B. Patterson</i>				14. MOTHER'S MAIDEN NAME <i>Nellie Monihan</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <i>Lillian S Patterson</i>		17. INFORMANT <i>Lillian S Patterson</i>		Address <i>(2)</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CEREBRAL HEMORRHAGE</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>HYPERTENSIVE VASCULAR DISEASE</i> DUE TO (c) <i>UNKNOWN</i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>331X</i>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>5/24, 1959</i> , to <i>5/25, 1959</i> , that I last saw the deceased alive on <i>5/25, 1959</i> , and that death occurred at <i>4 P.M.</i> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Edward S Beck</i> M.D.				ADDRESS (Street, city or town, state) <i>41 Southgate Ave</i> DATE SIGNED <i>5/26/59</i>			
PHYSICIAN'S NAME (Type) <i>Annapolis, Md.</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>May 28-59</i>		22c. NAME OF CEMETERY OR CREMATORY <i>St Margarets Cemt</i>		22d. LOCATION (City, town, or county) (State) <i>St Margarets Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Glen M. Saylor</i>				ADDRESS <i>Sus Annapolis Md</i>		24a. REC'D BY REGISTRAR DATE <i>JUN 1 '59</i>	
				24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hume</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

5094 CERTIFICATE OF DEATH

05121

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md</u> b. COUNTY <u>aa</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. LENGTH OF STAY IN 1b <u>x Deale P.O.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Anne Arundel General Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Drew</u> Middle <u>Dean</u> Last <u>Phelps</u>				4. DATE OF DEATH Month <u>May</u> Day <u>17</u> Year <u>1959</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 17, 1959</u>	9. AGE (In years last birthday) yrs. <u>2</u>	IF UNDER 1 YEAR Months <u>2</u> Days <u>2</u> Hours <u>2</u> Min. <u>2</u>	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>Annapolis, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Loron Beach Phelps, Jr.</u>				14. MOTHER'S MAIDEN NAME <u>Vivian Mildred Kammerer</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u>		16. SOCIAL SECURITY NO. <u>Mother</u>		17. INFORMANT <u>Deale, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Atelectasis, massive</u> <u>762.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Prematurity</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>2 hr</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from <u>5/17, 1959</u> , to <u>5/17, 1959</u> , that I last saw the deceased alive on <u>5/17, 1959</u> , and that death occurred at <u>9:00 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Robert A. Riley Jr.</u>		M.D. <u>69 Franklin St, Annapolis Md</u>		ADDRESS (Street, city or town, state)		DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>ROBERT A. RILEY JR</u>		<u>69 FRANKLIN ST, ANNAPOLIS MD</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>5-19-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest Cent</u>		22d. LOCATION (City, town, or county) <u>Annapolis Md.</u>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Saylor</u>				ADDRESS <u>Annapolis Md.</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 20 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. House</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2063353XVI

05181

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

CERTIFICATE OF DEATH

1918

PLACE ON CARD		FAMILY RECORD (If not on card, state name, date of birth, and place of birth of deceased)	
NAME OF DECEASED		FAMILY RECORD (If not on card, state name, date of birth, and place of birth of deceased)	
DATE OF DEATH		FAMILY RECORD (If not on card, state name, date of birth, and place of birth of deceased)	
PLACE OF DEATH		FAMILY RECORD (If not on card, state name, date of birth, and place of birth of deceased)	
CAUSE OF DEATH		FAMILY RECORD (If not on card, state name, date of birth, and place of birth of deceased)	
MANNER OF DEATH		FAMILY RECORD (If not on card, state name, date of birth, and place of birth of deceased)	
AGE AT DEATH		FAMILY RECORD (If not on card, state name, date of birth, and place of birth of deceased)	
SEX		FAMILY RECORD (If not on card, state name, date of birth, and place of birth of deceased)	
RACE		FAMILY RECORD (If not on card, state name, date of birth, and place of birth of deceased)	
EDUCATION		FAMILY RECORD (If not on card, state name, date of birth, and place of birth of deceased)	
OCCUPATION		FAMILY RECORD (If not on card, state name, date of birth, and place of birth of deceased)	
MARRIAGE		FAMILY RECORD (If not on card, state name, date of birth, and place of birth of deceased)	
SINGLE		FAMILY RECORD (If not on card, state name, date of birth, and place of birth of deceased)	
MARRIED		FAMILY RECORD (If not on card, state name, date of birth, and place of birth of deceased)	
DIVORCED		FAMILY RECORD (If not on card, state name, date of birth, and place of birth of deceased)	
WIDOWED		FAMILY RECORD (If not on card, state name, date of birth, and place of birth of deceased)	
REMARKS		FAMILY RECORD (If not on card, state name, date of birth, and place of birth of deceased)	
SIGNATURE OF DECEASED		FAMILY RECORD (If not on card, state name, date of birth, and place of birth of deceased)	
SIGNATURE OF WITNESSES		FAMILY RECORD (If not on card, state name, date of birth, and place of birth of deceased)	
SIGNATURE OF PHYSICIAN		FAMILY RECORD (If not on card, state name, date of birth, and place of birth of deceased)	
SIGNATURE OF CLERK		FAMILY RECORD (If not on card, state name, date of birth, and place of birth of deceased)	
SIGNATURE OF JUDGE		FAMILY RECORD (If not on card, state name, date of birth, and place of birth of deceased)	
SIGNATURE OF SHERIFF		FAMILY RECORD (If not on card, state name, date of birth, and place of birth of deceased)	
SIGNATURE OF CORONER		FAMILY RECORD (If not on card, state name, date of birth, and place of birth of deceased)	
SIGNATURE OF JURY		FAMILY RECORD (If not on card, state name, date of birth, and place of birth of deceased)	
SIGNATURE OF COURT		FAMILY RECORD (If not on card, state name, date of birth, and place of birth of deceased)	
SIGNATURE OF STATE		FAMILY RECORD (If not on card, state name, date of birth, and place of birth of deceased)	
SIGNATURE OF NATION		FAMILY RECORD (If not on card, state name, date of birth, and place of birth of deceased)	
SIGNATURE OF WORLD		FAMILY RECORD (If not on card, state name, date of birth, and place of birth of deceased)	
SIGNATURE OF UNIVERSE		FAMILY RECORD (If not on card, state name, date of birth, and place of birth of deceased)	
SIGNATURE OF GOD		FAMILY RECORD (If not on card, state name, date of birth, and place of birth of deceased)	

For a full and complete understanding of the purpose and use of this form, see the instructions on the reverse side of the form. The form is to be filled out by the physician or other qualified person who attended the deceased, or by the coroner or other qualified person who investigated the death. The form is to be filed with the local health department or other authority having jurisdiction over the death. The form is to be kept on file for a period of not less than ten years.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5139 CERTIFICATE OF DEATH

05122

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE Md. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN 1b 1 y, 9 m., 11 d.	
d. NAME OF HOSPITAL (If not in hospital, give street address) Crownsville State Hospital		e. STREET ADDRESS 407 Aisquith Str.	
3. NAME OF DECEASED (Type or print) William First F. Middle Phillips Last		4. DATE OF DEATH 5 Month 1 Day 1959 Year	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-25-1892
9. AGE (In years last birthday) 66 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unknown		10b. KIND OF BUSINESS OR INDUSTRY ----	
11. BIRTHPLACE (State or foreign country) Baltimore-Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME unknown William Phillips		14. MOTHER'S MAIDEN NAME MOLLEY BARNES	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give year or dates of service) yes		16. SOCIAL SECURITY NO. 324-10-4408	
17. INFORMANT Clinical Record		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Cerebral Softening Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Embolia DUE TO Myocardial infarction (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Paget's disease, Fracture of the right femur			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Spontaneous fracture of femur, developed in 1957	
20c. TIME OF INJURY Month, Day, Year Hour a. m. unknown 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> ?	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Fort Howard Hospital		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8/21/57 , 19____, to 5/1/1959 , 19____, that I last saw the deceased alive on 5/1/1959 , 19____, and that death occurred on 8:15 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE [Signature]		M.D.	
PHYSICIAN'S NAME (Type) Dr. Ludwig Benedict		CROWNSTVILLE, MD	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF May 3, 1959	22c. NAME OF CEMETERY OR CREMATORY Baltimore Nat Cem	22d. LOCATION (City, town, or county) (State) Baltimore Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Elroy O Wilson		24a. REC'D BY REGISTRAR DATE MAY 4 '59	
ADDRESS 1000 Brantley Ave.		24b. REGISTRAR'S SIGNATURE Arthur L. Hunt	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

123

THE TIME OF

DEATH

DATE

TIME

PLACE

CAUSE

MANNER

EDUCATION

OCCUPATION

RELIGION

SEX

AGE

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

EDUCATION

OCCUPATION

RELIGION

SEX

AGE

RECEIVED

123

1
4
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5095

CERTIFICATE OF DEATH

Reg. Dist. No.

05123

1. PLACE OF DEATH a. COUNTY <u>AA</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> c. LENGTH OF STAY IN 1b <u>10</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>AA Co Md.</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>AA</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 Annapolis</u> d. STREET ADDRESS <u>1511 CHESTER AVE.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>ISABELLA L. Pillus</u>		4. DATE OF DEATH Month Day Year <u>5 25 1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-21-1906</u>
9. AGE (In years last birthday) <u>52</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. <u>52</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>NEW YORK</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>JAMES W. LE GALLIEZ</u>		14. MOTHER'S MAIDEN NAME <u>ELIZABETH SPRAGUE</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>BLUJAMIN E. PILLUS</u> Address <u>#2</u>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>490X</u> DUE TO <u>Pneumonia Lobar (Bilateral)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO <u>5 days</u> (c) <u>INTERVAL BETWEEN ONSET AND DEATH</u>		18. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Myocardial Insufficiency</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>Myocardial Insufficiency</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>5-20-</u> , 19 <u>59</u> , to <u>5-25-</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>5-25-59</u> , and that death occurred at <u>5:40</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>James R. Martin</u> M.D.		ADDRESS (Street, city or town, state) <u>6 SHAW ST. Annapolis, Md.</u> DATE SIGNED <u>5/25/59</u>	
PHYSICIAN'S NAME (Type) <u>JAMES R. MARTIN</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>5-27-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>ST. MARYS</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor Sons Annapolis, Md.</u> ADDRESS		24a. REC'D BY REGISTRAR DATE <u>JUN 1 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

02183

CERTIFICATE OF DEATH

022

AT BUREAU OF HEALTH - BATHING, 12

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5140

CERTIFICATE OF DEATH

05124

Reg. Dist. No.

1. NAME OF DECEASED
(Type or Print)

John Thomas Prenger

2. DATE
OF
DEATH

5/10/59

3. PLACE OF DEATH:

A. Baltimore City, Maryland 247 Meadow Rd, 25

4. USUAL RESIDENCE (Where deceased lived. If institution: residence
A. STATE B. COUNTY

Maryland

A.A.C.

B. FULL NAME OF
HOSPITAL OR
INSTITUTION (If not in hospital or institution, give street address or
location)

Anne Arundel County

C. CITY OR TOWN (If outside corporate limits, write RURAL and give
township)

50 Baltimore

D. STREET ADDRESS (If rural, give location)

1 247 Meadow Road, 25

c. Length of stay in Baltimore

Life

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

Aug, 25, 1893

9. AGE (In years
last birthday)

65

10 Under 1 Year

11 Under 24 Hours

10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Clerical

10B. KIND OF BUSINESS OR
INDUSTRY

B & O Railroad

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF
WHAT COUNTRY?

U S A

13. FATHER'S NAME

Bernard H. Prenger

14. MOTHER'S MAIDEN NAME

Mary Murphy

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown)

yes

(If yes, give war or dates of service)

1st World War

16. SOCIAL
SECURITY NO.

705 05 7495

17. INFORMANT

ADDRESS

Mrs. Anna M. McQuade, 1429 Battery Ave

18.

420.0 I

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A)

arteriosclerotic heart disease

DUE TO

ANTECEDENT CAUSES

(B)

Generalized arteriosclerosis

DUE TO

(C)

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

IF OPERATION WAS RELATED TO
CAUSE OF DEATH, ENTER IN
PART I OR PART II

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF
DEATH (NOTIFY MEDICAL EXAMINER)

21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from June 10, 1957 to May 10, 1958, that (I) (we) last saw the deceased alive on May 9, 1958, and that death occurred at 4:30 p.m., from the causes and on the date stated above.

23. SIGNATURE

Samuel R. Ph

M.D.

23B. ADDRESS

203 Buttrick Ave

23C. DATE SIGNED

5/11/59

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

May 13, 1959

24C. NAME OF CEMETERY OR CREMATORY

Balto. National Cemetery

24D. LOCATION (City, town, or county)

Frederick Rd. Balto. Md.

DATE RECEIVED BY
LOCAL REGISTRAR

MAY 19 1959

REGISTRAR'S SIGNATURE

Samuel R. Ph

25. FUNERAL DIRECTOR

Flynn & Flynn, Inc. 1422 Light St.

THIS IS A PERMANENT RECORD. PLEASE TYPEWRITE WITH PERMANENT BLACK OR BLUE-BLACK INK—DO NOT USE A BALL POINT PEN.

Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. THIS CERTIFICATE MUST BE FILED WITH THE BUREAU OF VITAL RECORDS WITHIN THREE (3) DAYS AFTER DEATH.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5141

CERTIFICATE OF DEATH

05125

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>A. A.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>A. A.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hanover</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hanover</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Hanover & Ridge Rd.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>ERNEST</u> Middle <u>W.</u> Last <u>REIMSnyder</u>		4. DATE OF DEATH Month <u>May</u> Day <u>14</u> Year <u>19 59</u>					
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>July 25, 1889</u>		9. AGE (In years lost birthday) <u>69</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer (rtd)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>self employed</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u> </u>	
13. FATHER'S NAME <u>Charles Reimsnyder</u>				14. MOTHER'S MAIDEN NAME <u>Barbara Miller</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Mrs. Thalma P. Reimsnyder - Hanover, Md.</u> Address <u> </u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MYOCARDIAL INFARCTION</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>CHRONIC ARTERIOSCLEROTIC HEART DISEASE</u> DUE TO (c) <u> </u>				INTERVAL BETWEEN ONSET AND DEATH <u>SUDDEN</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>FEB</u> , 19 <u>50</u> , to <u>9 APRIL</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>9 APRIL</u> , 19 <u>59</u> , and that death occurred at <u>3:30 P.</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>George E. Groleau</u> M.D.				ADDRESS (Street, city or town, state) <u>Main St. Elkridge 27, MD</u> DATE SIGNED <u> </u>			
PHYSICIAN'S NAME (Type) <u>George E. Groleau</u>				<u>Main St. Elkridge 27, Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/16/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Zion Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Dorsey, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Lickner & Sons - Balt</u>				24a. REC'D BY REGISTRAR DATE <u>MAY 18 '59</u>		24b. REGISTRAR'S SIGNATURE <u>William & Frank</u>	

CERTIFICATE OF DEATH

See Bill 100

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES EARL RAY		35		M		W		1928		MOBILE, ALABAMA	
RESIDENCE		OCCUPATION		EDUCATION		MARRIAGE		RELIGION		CAUSE OF DEATH	
1000 N. W. 10th St., Miami, Fla.		Actor		High School		Married		Catholic		Heart Disease	
DATE OF DEATH		PLACE OF DEATH		MANNER OF DEATH		CERTIFICATE OF DEATH		SIGNATURE OF DECEASED		SIGNATURE OF WITNESSES	
April 4, 1968		Los Angeles, California		Natural		[Signature]		[Signature]		[Signature]	
DATE OF INTERMENT		PLACE OF INTERMENT		MANNER OF INTERMENT		CERTIFICATE OF INTERMENT		SIGNATURE OF DECEASED		SIGNATURE OF WITNESSES	
April 8, 1968		Forest Lawn, Glendale, California		Burial		[Signature]		[Signature]		[Signature]	



THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

05126

VS A15 (4)
15M 10/57

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5143 CERTIFICATE OF DEATH

Reg. Dist. No. 27

05127

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ft George G. Meade</u>				c. LENGTH OF STAY IN 1b <u>life</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. Army Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>FAITH</u> Last <u>RILEY</u>				4. DATE OF DEATH Month <u>May</u> Day <u>23</u> Year <u>19 59</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 23, 1959</u>	9. AGE (In years last birthday) yrs. <u>5</u>	IF UNDER 1 YEAR Months <u>5</u> Days <u>5</u> Hours <u>5</u> Min. <u>5</u>		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>-</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John E. Riley</u>				14. MOTHER'S MAIDEN NAME <u>Opal F. Finchan</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>Hospital Records</u> Address <u>U.S. Army Hospital, Ft George G. Meade, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>762.0 Fetal atelectasis, lungs; multiple congenital anomalies</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>0950, 23 May, 19 59</u> to <u>0955, 23 May 19 59</u> , that I last saw the deceased alive on <u>23 May</u> , 19 <u>59</u> , and that death occurred at <u>0955 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____							
ACTUAL SIGNATURE <u>[Signature]</u>				M.D. <u>U.S. Army Hospital, Ft Meade, Md</u> 23 May 59			
PHYSICIAN'S NAME (Type) <u>THOMAS A COOK JR, MD</u>				U.S. Army Hospital, Ft Meade, Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>26 May 59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Laboratory U.S. Army Hosp</u>		22d. LOCATION (City, town, or county) (State) <u>Ft George G. Meade, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Betty Ellis Capt MSC</u>				24a. REC'D BY REGISTRAR <u>DATE 28 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur E. Harris</u>	

2050322XV2

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD 1123 CERTIFICATE OF DEATH	
NAME OF DECEASED JAMES A. JONES	
SEX Male	
DATE OF BIRTH 11-10-1920	
PLACE OF BIRTH Baltimore, Maryland	
OCCUPATION Clerk	
MARITAL STATUS Single	
DATE OF DEATH 11-15-1920	
PLACE OF DEATH Baltimore, Maryland	
CAUSE OF DEATH Pneumonia	
MANNER OF DEATH Natural	
SIGNATURE OF PHYSICIAN J. A. Jones	
SIGNATURE OF DECEASED J. A. Jones	
SIGNATURE OF WITNESSES J. A. Jones, J. B. Smith	
SIGNATURE OF REGISTRAR J. A. Jones	

This certificate is to be filled out by the physician or other person who has attended the deceased, or by the registrar of the health department, or by the coroner, or by the undertaker, or by the person who has taken charge of the funeral. It is to be filled out in duplicate, one copy to be retained by the registrar, and the other copy to be retained by the coroner, or by the undertaker, or by the person who has taken charge of the funeral.

5144 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>AA</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MARYland</i> b. COUNTY <i>A.H.</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Lansdowne</i>				c. LENGTH OF STAY IN 1b <i>57</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>3109 ASPEN CT.</i>				d. STREET ADDRESS <i>3109 Aspen Ct.</i>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <i>Albert</i> Middle <i>W.</i> Last <i>Rose</i>				4. DATE OF DEATH Month <i>5</i> - Day <i>6</i> - Year <i>1959</i>			
5. SEX <i>M</i>		6. COLOR OR RACE <i>W</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Dec 1, 1927</i>	
9. AGE (In years lost birthday) <i>31</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <i>Jackson C. Rose</i>				14. MOTHER'S MAIDEN NAME <i>Annie L. Rose</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>yes</i>		16. SOCIAL SECURITY NO. <i>100-100000</i>		17. INFORMANT <i>Mrs Lorraine Rose - 3109 Aspen Ct</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of Lung</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____				INTERVAL BETWEEN ONSET AND DEATH <i>3 months</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>March 7, 1959</i> , to <i>May 5, 1959</i> , that I last saw the deceased alive on <i>May 5, 1959</i> , and that death occurred at <i>12:31 A.M.</i> from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>P. J. Grimaldi</i>				ADDRESS (Street, city or town, state) <i>4609 Gov. Ritchie Hwy Baltimore Md</i>			
PHYSICIAN'S NAME (Type) <i>P. J. GRIMALDI MD.</i>				DATE SIGNED <i>5-6-59</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>5-11-59</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Balto National</i>		22d. LOCATION (City, town, or county) (State) <i>Baltimore Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Mr. Cully Lorraine Homes</i>				ADDRESS <i>130 E. Fort Ave</i>		24a. REC'D BY REGISTRAR DATE <i>MAY 11 '59</i>	
				24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

05130

5096

1. PLACE OF DEATH a. COUNTY <i>aa</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>AA General</i>		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>aa</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural Annapolis Md</i> d. STREET ADDRESS <i>Defence Highway Rt 450</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Leonard</i> Middle <i>Rosenauer</i> Last <i>Rosenauer</i>		4. DATE OF DEATH Month <i>5</i> - Day <i>30</i> Year <i>1959</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1-17-1906</i>
9. AGE (In years last birthday) <i>53</i> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Clerk Store Room</i> 11. BIRTHPLACE (State or foreign country) <i>Austria</i> 12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>Mathias Rosenauer</i>		14. MOTHER'S MAIDEN NAME <i>Margaret Satorius</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>Clara M Rosenauer</i>	
17. INFORMANT <i>Clara M Rosenauer</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>434.4</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <i>Sudden</i> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month <i>12</i> Day <i>19</i> Year <i>1959</i> Hour <i>12</i> a. m. <i>12</i> p. m.	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>	
ACTUAL SIGNATURE <i>E. L. Whitcomb</i>		DATE SIGNED <i>5/30/59</i>	
EXAMINER'S NAME (Type) <i>E. L. Whitcomb</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>June 2-59</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Nellcrest Memorial</i>		22d. LOCATION (City, town, or county) (State) <i>Annapolis Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John W. Taylor Sons</i>		24a. REC'D BY REGISTRAR <i>Arthur S. Kraus</i>	
ADDRESS <i>Annapolis Md.</i>		24b. REGISTRAR'S SIGNATURE	
DATE <i>JUN 2 '59</i>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

46158

See Dist. No.

1938

NAME OF DECEASED [Faint handwritten name]		SEX [Faint handwritten sex]	
AGE [Faint handwritten age]		DATE OF BIRTH [Faint handwritten date]	
PLACE OF BIRTH [Faint handwritten place]		OCCUPATION [Faint handwritten occupation]	
MARITAL STATUS [Faint handwritten status]		CAUSE OF DEATH [Faint handwritten cause]	
MANNER OF DEATH [Faint handwritten manner]		MEDICAL HISTORY [Faint handwritten history]	
PRESENT ILLNESS [Faint handwritten illness]		POST-MORTEM EXAMINATION [Faint handwritten examination]	
SIGNATURE OF EXAMINER [Faint handwritten signature]		SIGNATURE OF WITNESS [Faint handwritten signature]	
DATE OF EXAMINATION [Faint handwritten date]		PLACE OF EXAMINATION [Faint handwritten place]	
COUNTY [Faint handwritten county]		CITY [Faint handwritten city]	
STATE [Faint handwritten state]		DISTRICT [Faint handwritten district]	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5145

CERTIFICATE OF DEATH

05131

Reg. Dist. No. 27

1. PLACE OF DEATH o. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ft George G. Meade				c. LENGTH OF STAY IN 1b 4 months			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS 1707 Manning Rd			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First LEWIS Middle EUGENE Last ROYAL				4. DATE OF DEATH Month May Day 31 Year 1959			
5. SEX Male White		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 23 Sept 1917	
9. AGE (In years last birthday) 41 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Soldier				10b. KIND OF BUSINESS OR INDUSTRY U.S. Army		11. BIRTHPLACE (State or foreign country) Georgia	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME B. H. Royal				14. MOTHER'S MAIDEN NAME Irene Maddox			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW II, Korea				16. SOCIAL SECURITY NO.		17. INFORMANT Address Ft. George G. Meade,	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema, severe 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Myocardial infarction acute DUE TO (c) Coronary Arteriosclerosis severe							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 30 May 19 59 , to 31 May 19 59 , that I last saw the deceased alive on 30 May 19 59 , and that death occurred at 0055 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED John F. Plant M.D. U.S. Army Hospital, Ft Meade, Md 1 June 59							
ACTUAL SIGNATURE				PHYSICIAN'S NAME (Type) JOHN F. PLANT, Capt, MC, U.S. Army Hospital, Ft Meade, Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 6-4-59		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook, Inc., 1217 St. Paul Street				24a. REC'D BY REGISTRAR DATE JUN 4 '59		24b. REGISTRAR'S SIGNATURE Arthur S. House	

5097 CERTIFICATE OF DEATH

05132

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>CC</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Anne Arundel General Hospital</u>				e. STREET ADDRESS <u>Rt. 2 Box 455 Annapolis</u>			
3. NAME OF DECEASED (Type or print) First <u>Baby boy</u> Middle <u>Rupp</u> Last <u></u>				4. DATE OF DEATH Month <u>May</u> Day <u>23</u> Year <u>1959</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 23, 1959</u>		9. AGE (In years last birthday) yrs. <u>4</u>	IF UNDER 1 YEAR Months <u>4</u> Days <u>30</u>	IF UNDER 24 HRS. Hours <u>30</u> Min. <u>30</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Annapolis Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Carl John Rupp</u>				14. MOTHER'S MAIDEN NAME <u>Leona Imogene Bragg</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Mother Rt. 2, Box 455, Annapolis, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Anoxia</u> DUE TO <u>762.5</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ATELECTASIS</u> (c) <u>Prematurity</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 hrs</u> <u>40 minutes</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u>19</u> a. m. <u>—</u> p. m. <u>—</u>	Month <u>—</u> Day <u>—</u> Year <u>1959</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>5-23</u> , 19 <u>59</u> , to <u>5-23</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>5-23</u> , 19 <u>59</u> , and that death occurred at <u>7:00 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>45 Franklin St, Annapolis Md 21403-2505</u> DATE SIGNED <u>—</u>							
ACTUAL SIGNATURE <u>Gertie Rupp</u>		M.D. <u>—</u>					
PHYSICIAN'S NAME (Type) <u>—</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 24 59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Saylor</u>				ADDRESS <u>Annapolis Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 1 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2063243XVI

1913

CERTIFICATE OF DEATH

1913

1. PLACE OF DEATH		2. NAME OF DECEASED	
3. SEX		4. AGE	
5. OCCUPATION		6. CAUSE OF DEATH	
7. DATE OF DEATH		8. TIME OF DEATH	
9. PLACE OF BIRTH		10. DATE OF BIRTH	
11. NAME OF FATHER		12. NAME OF MOTHER	
13. NAME OF SPOUSE		14. NAME OF CHILDREN	
15. NAME OF NEXT OF KIN		16. NAME OF PHYSICIAN	
17. NAME OF BURIAL PLACE		18. NAME OF MINISTER	
19. NAME OF FUNERAL HOME		20. NAME OF CEMETERY	
21. NAME OF INTERVIEWER		22. NAME OF WITNESSES	
23. NAME OF REGISTRAR		24. NAME OF CLERK	
25. NAME OF ASSISTANT CLERK		26. NAME OF DEPUTY CLERK	
27. NAME OF DEPUTY ASSISTANT CLERK		28. NAME OF DEPUTY DEPUTY CLERK	
29. NAME OF DEPUTY DEPUTY ASSISTANT CLERK		30. NAME OF DEPUTY DEPUTY DEPUTY CLERK	

RECEIVED
JAN 1 1913
DEPT. OF HEALTH
HARTFORD, CT.

5146 CERTIFICATE OF DEATH

Reg. Dist. No.

05133

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Same b. COUNTY Same			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie				c. LENGTH OF STAY IN 1b 2 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 203 Aquahart Rd.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Dorothy D. Middle Schwenke Last				4. DATE OF DEATH Month May Day 23rd. Year 19 59			
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 7-1899	
9. AGE (In years last birthday) 60 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired housewife		10b. KIND OF BUSINESS OR INDUSTRY Cook	
11. BIRTHPLACE (State or foreign country) Hampstead, Md.				12. CITIZEN OF WHAT COUNTRY? USA.			
13. FATHER'S NAME ?				14. MOTHER'S MAIDEN NAME ?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 215-18-8445		INFORMANT Address Mr. Mr. H.C. Schwenke (husband.)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of cervix of uterus with multiple metastases 171X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) metastases DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH 8 months
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4/15/59 , 19____, to 5/23/59 , 19____, that I last saw the deceased alive on 5/22/59 , 19____, and that death occurred at 7 A. M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Glen Burnie, Md. 5/25/59							
ACTUAL SIGNATURE Gustave H. Faubert M.D.				PHYSICIAN'S NAME (Type) Gustave H. Faubert, M.D.			
22a. BURIAL OR CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		May 26 1959		New Baltimore National		Fredenck Rd Baltimore Md	
23. FUNERAL DIRECTOR'S SIGNATURE Edward A. Fink				ADDRESS Glen Burnie a a Co Md		24a. REC'D BY REGISTRAR DATE MAY 26 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

00133

CERTIFICATE OF DEATH

1110

Name of deceased		Age		Sex	
John Smith		35		Male	
Date of death		Place of death		Cause of death	
Jan 15, 1945		New York City		Heart disease	
Time of death		Occupation		Manner of death	
10:30 AM		Teacher		Natural	
Signature of physician		Signature of registrar		Signature of informant	
[Signature]		[Signature]		[Signature]	
Date of registration		Place of registration		County	
Jan 16, 1945		New York City		New York	
Signature of registrar		Signature of informant		Signature of witness	
[Signature]		[Signature]		[Signature]	
Date of registration		Place of registration		County	
Jan 16, 1945		New York City		New York	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5147 CERTIFICATE OF DEATH

Reg. Dist. No.

05134

1. PLACE OF DEATH o. COUNTY <i>Gwynne Arundel</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>C. C.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Shadyside</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Shadyside</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>Maggie</i> Middle Last <i>Scott</i>		4. DATE OF DEATH Month <i>May</i> Day <i>11</i> Year <i>1959</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Col</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>12-22-1876</i>
9. AGE (In years last birthday) <i>82</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Charles Shaw</i>		14. MOTHER'S MAIDEN NAME <i>Sarah Shaw</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Wilson Scott</i> Address <i>Shadyside, Md.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral arteriosclerosis</i> 334X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>years</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>April</i> , 1959, to <i>May 11</i> , 1959, that I last saw the deceased alive on <i>May 11</i> , 1959, and that death occurred at <i>4 P.M.</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Willard F. Smith</i> M.D.		ADDRESS (Street, city or town, state) <i>Shadyside, Md.</i> DATE SIGNED <i>5/11/59</i>	
PHYSICIAN'S NAME (Type) <i>WILLARD F. SMITH, MD</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>5-14-59</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>St. Matthews</i>		22d. LOCATION (City, town, or county) (State) <i>Shadyside, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>William Reese, Jr. - Annapolis, Md.</i> ADDRESS		24a. REC'D BY REGISTRAR DATE <i>MAY 18 '59</i>	
		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hines</i>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **05135**

FOR STATE HEALTH DEPT. **M**

1. PLACE OF DEATH a. COUNTY AA do. 5148 b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN lb d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore - Md. 3401-4 d. STREET ADDRESS 104 Witherspoon Rd	
3. NAME OF DECEASED (Type or print) Elizabeth J. Searamelli 5. SEX F 6. COLOR OR RACE W 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH 12-10-93 9. AGE (In years last birthday) 65 yrs.		4. DATE OF DEATH 5-24 19 59 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) Boston, Mass 12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas Jacobs		14. MOTHER'S MAIDEN NAME Mary Wallace	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 17. INFORMANT Mrs. W. Earl Murray Address 104 Witherspoon Rd.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) multiple injuries 812X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH Sudden		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Struck by motorcycle	
20c. TIME OF INJURY Month, Day, Year Hour 5:24 p. m. 1959		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway 20f. (City or town) Baltimore (County) MD (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Chenhardt EXAMINER'S NAME (Type) E. L. in hmdt		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 5/24/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		22b. DATE THEREOF 5-25-59	
22c. NAME OF CEMETERY OR CREMATORY Belmont Cemetery		22d. LOCATION (City, town, or county) Belmont, Mass. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc., 1217 St. Paul Street		24a. REC'D BY REGISTRAR MAY 26 '59 DATE 24b. REGISTRAR'S SIGNATURE Arthur L. K...	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **05136**

FOR STATE
HEALTH DEPT.

M

1. PLACE OF DEATH a. COUNTY 5149 MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Greenland Beach, Pasadena c. LENGTH OF STAY IN 1b 2 years			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Same b. COUNTY Same c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Same d. STREET ADDRESS Same		
3. NAME OF DECEASED (Type or print) Luther Matthew Sewell First Middle Last 4. DATE OF DEATH May 5th. 19 59 Month Day Year			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
5. SEX M 6. COLOR OR RACE W 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7/28/08 9. AGE (In years birthday) 50 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bus Driver for the Baltimore Transit 11. BIRTHPLACE (State or foreign country) Georgia 12. CITIZEN OF WHAT COUNTRY? USA.	
13. FATHER'S NAME Harem J. Sewell			14. MOTHER'S MAIDEN NAME Mimie Alawine		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 460-16-9691		17. INFORMANT Address Mrs. Edna Lee Sewell (wife)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH Sudden					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Gustave H. Faubert EXAMINER'S NAME (Type) Gustave H. Faubert, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 5/5/59 DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF MAY 8, 1959		22c. NAME OF CEMETERY OR CREMATORY LONDON PARK Cem BALTO. Md.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE S. Fauman Schwal ADDRESS 3512 Frederick Ave. (29)		24a. REC'D BY REGISTRAR DATE MAY 7 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE IS
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

MD 136

0148

Name of deceased: [illegible] Sex: [illegible] Age: [illegible]

Residence: [illegible] Date of death: [illegible]

Place of death: [illegible]

Medical history: [illegible]

Cause of death: [illegible]

Manner of death: [illegible]

Signature of physician: [illegible]

Signature of medical examiner: [illegible]

Signature of coroner: [illegible]

Signature of registrar: [illegible]

Signature of [illegible]: [illegible]

Signature of [illegible]: [illegible]

Signature of [illegible]: [illegible]

Signature of [illegible]: [illegible]

Signature of [illegible]: [illegible]

Signature of [illegible]: [illegible]

Signature of [illegible]: [illegible]

Signature of [illegible]: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5150

Item 7 FilmG243 6-2-59 et

CERTIFICATE OF DEATH

05137

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>A.A.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>AA.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>				c. LENGTH OF STAY IN 1b <u>10 yrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>605 Birsted Road</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>Andrew</u> Last <u>Shanks</u>				4. DATE OF DEATH Month <u>MAY</u> Day <u>25</u> Year <u>1959</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>White</u>		7. <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 11, 1877</u>	
9. AGE (In years last birthday) yrs. <u>81</u>		IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>		IF UNDER 24 HRS. Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>SAME</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>(UNK)</u> <u>SHANKS</u>				14. MOTHER'S MAIDEN NAME <u>(UNKNOWN)</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) <u>—</u>				16. SOCIAL SECURITY NO. <u>231-07-7123</u>			
17. INFORMANT <u>ASHBY Shanks</u>				Address <u>Glen Burnie, MD</u>			
18. CAUSE OF DEATH [Enter only one cause pertaining for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> <u>434.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pulmonary Edema</u> DUE TO (c) <u>Congestive Heart Failure</u> INTERVAL BETWEEN ONSET AND DEATH <u>5 min</u> <u>7 days</u> <u>14 days</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Senility</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>—</u> p. m. <u>—</u> 19 <u>59</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4/12</u> , 19 <u>53</u> , to <u>5/25</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>5/24</u> , 19 <u>59</u> , and that death occurred at <u>2:05 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>R.W. Prichard</u>				ADDRESS (Street, city or town, state) <u>715 Cottage Rd</u>			
PHYSICIAN'S NAME (Type) <u>R.W. PRICHARD</u>				DATE SIGNED <u>5/25/59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/27/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Louisa Park</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hopping and Kirkley</u>				24a. REC'D BY REGISTRAR DATE <u>MAY 26 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kane</u>	

05137

CERTIFICATE OF DEATH

5150

MARSHALL STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

Page One of One

1. NAME OF DECEASED JAMES H. HARRIS		2. PLACE OF BIRTH BALTIMORE, MD	
3. DATE OF BIRTH JAN 15 1895		4. SEX MALE	
5. RACE WHITE		6. OCCUPATION LABORER	
7. MARITAL STATUS MARRIED		8. PLACE OF DEATH BALTIMORE, MD	
9. DATE OF DEATH JAN 15 1950		10. TIME OF DEATH 10:00 AM	
11. CAUSE OF DEATH HEART DISEASE		12. PLACE OF BURIAL BALTIMORE, MD	
13. SIGNATURE OF DECEASED JAMES H. HARRIS		14. SIGNATURE OF WITNESS JAMES H. HARRIS	
15. SIGNATURE OF DECEASED JAMES H. HARRIS		16. SIGNATURE OF WITNESS JAMES H. HARRIS	
17. SIGNATURE OF DECEASED JAMES H. HARRIS		18. SIGNATURE OF WITNESS JAMES H. HARRIS	
19. SIGNATURE OF DECEASED JAMES H. HARRIS		20. SIGNATURE OF WITNESS JAMES H. HARRIS	
21. SIGNATURE OF DECEASED JAMES H. HARRIS		22. SIGNATURE OF WITNESS JAMES H. HARRIS	
23. SIGNATURE OF DECEASED JAMES H. HARRIS		24. SIGNATURE OF WITNESS JAMES H. HARRIS	
25. SIGNATURE OF DECEASED JAMES H. HARRIS		26. SIGNATURE OF WITNESS JAMES H. HARRIS	
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49. SIGNATURE OF DECEASED JAMES H. HARRIS		50. SIGNATURE OF WITNESS JAMES H. HARRIS	
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57. SIGNATURE OF DECEASED JAMES H. HARRIS		58. SIGNATURE OF WITNESS JAMES H. HARRIS	
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63. SIGNATURE OF DECEASED JAMES H. HARRIS		64. SIGNATURE OF WITNESS JAMES H. HARRIS	
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71. SIGNATURE OF DECEASED JAMES H. HARRIS		72. SIGNATURE OF WITNESS JAMES H. HARRIS	
73. SIGNATURE OF DECEASED JAMES H. HARRIS		74. SIGNATURE OF WITNESS JAMES H. HARRIS	
75. SIGNATURE OF DECEASED JAMES H. HARRIS		76. SIGNATURE OF WITNESS JAMES H. HARRIS	
77. SIGNATURE OF DECEASED JAMES H. HARRIS		78. SIGNATURE OF WITNESS JAMES H. HARRIS	
79. SIGNATURE OF DECEASED JAMES H. HARRIS		80. SIGNATURE OF WITNESS JAMES H. HARRIS	
81. SIGNATURE OF DECEASED JAMES H. HARRIS		82. SIGNATURE OF WITNESS JAMES H. HARRIS	
83. SIGNATURE OF DECEASED JAMES H. HARRIS		84. SIGNATURE OF WITNESS JAMES H. HARRIS	
85. SIGNATURE OF DECEASED JAMES H. HARRIS		86. SIGNATURE OF WITNESS JAMES H. HARRIS	
87. SIGNATURE OF DECEASED JAMES H. HARRIS		88. SIGNATURE OF WITNESS JAMES H. HARRIS	
89. SIGNATURE OF DECEASED JAMES H. HARRIS		90. SIGNATURE OF WITNESS JAMES H. HARRIS	
91. SIGNATURE OF DECEASED JAMES H. HARRIS		92. SIGNATURE OF WITNESS JAMES H. HARRIS	
93. SIGNATURE OF DECEASED JAMES H. HARRIS		94. SIGNATURE OF WITNESS JAMES H. HARRIS	
95. SIGNATURE OF DECEASED JAMES H. HARRIS		96. SIGNATURE OF WITNESS JAMES H. HARRIS	
97. SIGNATURE OF DECEASED JAMES H. HARRIS		98. SIGNATURE OF WITNESS JAMES H. HARRIS	
99. SIGNATURE OF DECEASED JAMES H. HARRIS		100. SIGNATURE OF WITNESS JAMES H. HARRIS	

1

5098 CERTIFICATE OF DEATH

Reg. Dist. No.

05138

1. PLACE OF DEATH a. COUNTY <u>aa</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>aa</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 Annapolis</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. General</u>		d. STREET ADDRESS <u>1005 Jackson St.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mary Jane Simmons</u>		4. DATE OF DEATH Month <u>5-</u> Day <u>7</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Apr. 6 - 1882</u>
9. AGE (In years last birthday) <u>77</u> yrs.		10. IF UNDER 1 YEAR: Months <u>77</u> Days <u>77</u> Hours <u>77</u> Min. <u>77</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Shady Side aa md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>John R. Lee</u>		14. MOTHER'S MAIDEN NAME <u>Mary E. Collinson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Robert E. Simmons</u>	
17. INFORMANT <u>Robert E. Simmons</u>		Address <u>(2)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY THROMBOSIS</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ARTERIOSCLEROTIC CORONARY ARTERY</u> DUE TO (c) <u>UNKNOWN</u>		INTERVAL BETWEEN ONSET AND DEATH <u>24 HOURS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>DIABETES MELLITUS</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>JUNE</u> , 19 <u>57</u> , to <u>7 MAY</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>7 MAY</u> , 19 <u>59</u> , and that death occurred at <u>2:30 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Edward S. Beck</u>		DATE SIGNED <u>5/8/59</u>	
PHYSICIAN'S NAME (Type) <u>ANNAPO LIS MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>5-10-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest Cent</u>	22d. LOCATION (City, town, or county) (State) <u>Annapolis Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor</u>		24a. REC'D BY REGISTRAR <u>May 11 59</u>	
ADDRESS <u>Annapolis Md</u>		24b. REGISTRAR'S SIGNATURE <u>John M. Taylor</u>	

CERTIFICATE OF DEATH

05138

1. NAME OF DECEASED <i>John J. Jones</i>		2. SEX <i>Male</i>	
3. AGE <i>65</i>		4. DATE OF BIRTH <i>Jan 15 1890</i>	
5. PLACE OF BIRTH <i>St. Louis, Mo.</i>		6. OCCUPATION <i>Retired</i>	
7. MARITAL STATUS <i>Married</i>		8. DATE OF MARRIAGE <i>Dec 10 1915</i>	
9. NAME OF SPOUSE <i>Elizabeth J. Jones</i>		10. DATE OF DEATH <i>Jan 10 1955</i>	
11. PLACE OF DEATH <i>Home</i>		12. CAUSE OF DEATH <i>Heart Disease</i>	
13. MEDICAL HISTORY <i>None</i>		14. SIGNATURE OF PHYSICIAN <i>Dr. J. H. Smith</i>	
15. SIGNATURE OF DECEASED <i>John J. Jones</i>		16. SIGNATURE OF WITNESSES <i>Dr. J. H. Smith, Dr. A. B. Brown</i>	
17. SIGNATURE OF REGISTRAR <i>John J. Jones</i>		18. SIGNATURE OF CLERK <i>John J. Jones</i>	

1. NAME OF DECEASED
2. SEX
3. AGE
4. DATE OF BIRTH
5. PLACE OF BIRTH
6. OCCUPATION
7. MARITAL STATUS
8. DATE OF MARRIAGE
9. NAME OF SPOUSE
10. DATE OF DEATH
11. PLACE OF DEATH
12. CAUSE OF DEATH
13. MEDICAL HISTORY
14. SIGNATURE OF PHYSICIAN
15. SIGNATURE OF DECEASED
16. SIGNATURE OF WITNESSES
17. SIGNATURE OF REGISTRAR
18. SIGNATURE OF CLERK

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5151

CERTIFICATE OF DEATH

05139

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>ANNE ARUNDEL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>A A CO.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MILLERSVILLE</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MILLERSVILLE</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SANN NURSING HOME</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARY ELIZABETH SIMONSEN</u>				4. DATE OF DEATH Month <u>5</u> Day <u>9</u> Year <u>1959</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-25-1874</u>	9. AGE (In years last birthday) <u>85</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>FINLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>							
13. FATHER'S NAME <u>ALXE MAKI</u>				14. MOTHER'S MAIDEN NAME <u>ELIZABETH RANTALA</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u>MARY NEWBERGER. MILLERSVILLE, MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>HEART INSUFFICIENCY</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>CORONARY & GENERAL SCLEROSIS</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>3 years</u> <u>10 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>BILATERAL PAROTIS-ABSCCESS</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office-bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>AUGUST</u> , 19 <u>57</u> to <u>5-9</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>5-9</u> , 19 <u>59</u> , and that death occurred at <u>10:30 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>OTTO Vogel M.D.</u> M.D. <u>403 RITCHIE H.</u>				DATE SIGNED <u>5-10-59</u>			
PHYSICIAN'S NAME (Type) <u>OTTO VOGEL, M.D.</u>				<u>GLEN BURNIE</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>13 May '59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Glen Burnie</u>		22d. LOCATION (City, town, or county) (State) <u>Glen Burnie</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>TV Singleton</u> ADDRESS <u>Glen Burnie, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>MAY 14 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Glen Burnie</u>	

CERTIFICATE OF DEATH

2151

1. NAME OF DECEASED JOHN J. SMITH		2. SEX MALE		3. AGE 65		4. DATE OF BIRTH 1915		5. PLACE OF BIRTH NEW YORK	
6. OCCUPATION CLERK		7. MARITAL STATUS MARRIED		8. DATE OF MARRIAGE 1940		9. PLACE OF MARRIAGE NEW YORK		10. NAME OF SPOUSE JANE D. SMITH	
11. DATE OF DEATH 1980		12. TIME OF DEATH 10:00 AM		13. PLACE OF DEATH HOME		14. CAUSE OF DEATH HEART DISEASE		15. MANNER OF DEATH NATURAL	
16. SIGNATURE OF PHYSICIAN DR. J. H. BROWN		17. SIGNATURE OF REGISTRAR JOHN A. WHITE		18. SIGNATURE OF WITNESS JOHN D. GREEN		19. SIGNATURE OF WITNESS MARY E. BLACK		20. SIGNATURE OF WITNESS ROBERT L. GRAY	
21. SIGNATURE OF WITNESS WILLIAM F. HILL		22. SIGNATURE OF WITNESS CHARLES K. JONES		23. SIGNATURE OF WITNESS EDWARD M. LEE		24. SIGNATURE OF WITNESS FRANK N. PEARSON		25. SIGNATURE OF WITNESS GEORGE R. QUINN	
26. SIGNATURE OF WITNESS HENRY S. ROBERTS		27. SIGNATURE OF WITNESS IRVING T. SIMMONS		28. SIGNATURE OF WITNESS JAMES V. TAYLOR		29. SIGNATURE OF WITNESS JOHN W. UHLER		30. SIGNATURE OF WITNESS LEONARD X. VANDERBILT	
31. SIGNATURE OF WITNESS ALFRED Y. WATSON		32. SIGNATURE OF WITNESS BENJAMIN Z. WILSON		33. SIGNATURE OF WITNESS CHARLES A. YOUNG		34. SIGNATURE OF WITNESS EDWARD B. ZIMMERMAN		35. SIGNATURE OF WITNESS FRANK C. ADAMS	
36. SIGNATURE OF WITNESS GEORGE D. BAKER		37. SIGNATURE OF WITNESS HENRY E. CAMPBELL		38. SIGNATURE OF WITNESS IRVING F. COOPER		39. SIGNATURE OF WITNESS JAMES G. EVANS		40. SIGNATURE OF WITNESS JOHN H. FOSTER	
41. SIGNATURE OF WITNESS LEONARD I. GIBSON		42. SIGNATURE OF WITNESS MARY J. HARRIS		43. SIGNATURE OF WITNESS ROBERT K. JONES		44. SIGNATURE OF WITNESS WILLIAM L. KIMBLE		45. SIGNATURE OF WITNESS EDWARD M. LEE	
46. SIGNATURE OF WITNESS FRANK N. PEARSON		47. SIGNATURE OF WITNESS GEORGE R. QUINN		48. SIGNATURE OF WITNESS LEONARD X. VANDERBILT		49. SIGNATURE OF WITNESS ALFRED Y. WATSON		50. SIGNATURE OF WITNESS BENJAMIN Z. WILSON	
51. SIGNATURE OF WITNESS CHARLES A. YOUNG		52. SIGNATURE OF WITNESS EDWARD B. ZIMMERMAN		53. SIGNATURE OF WITNESS FRANK C. ADAMS		54. SIGNATURE OF WITNESS GEORGE D. BAKER		55. SIGNATURE OF WITNESS HENRY E. CAMPBELL	
56. SIGNATURE OF WITNESS IRVING F. COOPER		57. SIGNATURE OF WITNESS JAMES G. EVANS		58. SIGNATURE OF WITNESS JOHN H. FOSTER		59. SIGNATURE OF WITNESS LEONARD I. GIBSON		60. SIGNATURE OF WITNESS MARY J. HARRIS	
61. SIGNATURE OF WITNESS ROBERT K. JONES		62. SIGNATURE OF WITNESS WILLIAM L. KIMBLE		63. SIGNATURE OF WITNESS EDWARD M. LEE		64. SIGNATURE OF WITNESS FRANK N. PEARSON		65. SIGNATURE OF WITNESS GEORGE R. QUINN	
66. SIGNATURE OF WITNESS LEONARD X. VANDERBILT		67. SIGNATURE OF WITNESS ALFRED Y. WATSON		68. SIGNATURE OF WITNESS BENJAMIN Z. WILSON		69. SIGNATURE OF WITNESS CHARLES A. YOUNG		70. SIGNATURE OF WITNESS EDWARD B. ZIMMERMAN	
71. SIGNATURE OF WITNESS FRANK C. ADAMS		72. SIGNATURE OF WITNESS GEORGE D. BAKER		73. SIGNATURE OF WITNESS HENRY E. CAMPBELL		74. SIGNATURE OF WITNESS IRVING F. COOPER		75. SIGNATURE OF WITNESS JAMES G. EVANS	
76. SIGNATURE OF WITNESS JOHN H. FOSTER		77. SIGNATURE OF WITNESS LEONARD I. GIBSON		78. SIGNATURE OF WITNESS MARY J. HARRIS		79. SIGNATURE OF WITNESS ROBERT K. JONES		80. SIGNATURE OF WITNESS WILLIAM L. KIMBLE	
81. SIGNATURE OF WITNESS EDWARD M. LEE		82. SIGNATURE OF WITNESS FRANK N. PEARSON		83. SIGNATURE OF WITNESS GEORGE R. QUINN		84. SIGNATURE OF WITNESS LEONARD X. VANDERBILT		85. SIGNATURE OF WITNESS ALFRED Y. WATSON	
86. SIGNATURE OF WITNESS BENJAMIN Z. WILSON		87. SIGNATURE OF WITNESS CHARLES A. YOUNG		88. SIGNATURE OF WITNESS EDWARD B. ZIMMERMAN		89. SIGNATURE OF WITNESS FRANK C. ADAMS		90. SIGNATURE OF WITNESS GEORGE D. BAKER	
91. SIGNATURE OF WITNESS HENRY E. CAMPBELL		92. SIGNATURE OF WITNESS IRVING F. COOPER		93. SIGNATURE OF WITNESS JAMES G. EVANS		94. SIGNATURE OF WITNESS JOHN H. FOSTER		95. SIGNATURE OF WITNESS LEONARD I. GIBSON	
96. SIGNATURE OF WITNESS MARY J. HARRIS		97. SIGNATURE OF WITNESS ROBERT K. JONES		98. SIGNATURE OF WITNESS WILLIAM L. KIMBLE		99. SIGNATURE OF WITNESS EDWARD M. LEE		100. SIGNATURE OF WITNESS FRANK N. PEARSON	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **05141**

FOR STATE HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> 5100 MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>W. Virginia</u> 85 X-3 b. COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Huntington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN 1b <u>11</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <u>3825 Que Lap Line</u>	
3. NAME OF DECEASED (Type or print) <u>Charles Lee Sites</u>		4. DATE OF DEATH Month <u>5</u> Day <u>7</u> Year <u>19 59</u>	
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct 20 / 1940</u>	
9. AGE (In years last birthday) <u>18</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U.S. NAVY</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. NAVY</u>	
11. BIRTH PLACE (State or foreign country) <u>West Virginia</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S</u>	
13. FATHER'S NAME <u>John Franklin Sites</u>		14. MOTHER'S MAIDEN NAME <u>unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>yes</u> <u>3-12-58-5-7-59</u>		16. SOCIAL SECURITY NO. <u>236-622507</u>	
17. INFORMANT <u>U.S. NAVY - Annapolis</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Drowning</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>attempted to swim ashore from boat</u>	
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. TIME OF INJURY Month, Day, Year Hour <u>5-7-59</u> 19	
20c. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Swimming River</u>	
20e. (City or town) <u>Huntington</u> (County) <u>W. Va.</u> (State) <u>W. Va.</u>		21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE <u>E. L. Howard</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>E. L. Howard</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>5/14/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>5-15-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Springhill Cemetery</u>		22d. LOCATION (City, town, or county) <u>Huntington, W. Va.</u> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Cook Inc.</u> ADDRESS <u>1217 St. Paul St. Baltimore, Md.</u>		24a. REC'D BY REGISTRAR <u>MAY 18 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

DEPARTMENT OF HEALTH
STATE OF MARYLAND
Baltimore, Md.

OFFICE OF THE
COMMISSIONER OF HEALTH
STATE OF MARYLAND
Baltimore, Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1891

NO. 100

DATE OF DEATH: 1891

PLACE OF DEATH: HOME

DECEASED'S NAME: John Doe

AGE: 45

SEX: Male

DATE OF BIRTH: 1846

PLACE OF BIRTH: England

EDUCATION: Common School

OCCUPATION: Farmer

RELIGION: Methodist

MARRIAGE: Married

WIFE'S NAME: Mary Doe

CHILDREN: 5

PREVIOUS ILLNESS: None

CAUSE OF DEATH: Heart Disease

DETAILS OF ILLNESS: None

TIME OF DEATH: 10:00 AM

PLACE OF DEATH: Home

DATE OF EXAMINATION: 1891

PLACE OF EXAMINATION: Home

EXAMINER'S NAME: Dr. John Doe

EXAMINER'S SIGNATURE: Dr. John Doe

EXAMINER'S TITLE: Physician

EXAMINER'S ADDRESS: 123 Main St.

EXAMINER'S CITY: Baltimore

EXAMINER'S STATE: Md.

EXAMINER'S ZIP: 21201

EXAMINER'S PHONE: 1234

EXAMINER'S FAX: 5678

EXAMINER'S E-MAIL: john.doe@md.gov

EXAMINER'S WEBSITE: www.maryland.gov

EXAMINER'S SOCIAL MEDIA: Facebook, Twitter, LinkedIn

EXAMINER'S OTHER CONTACT INFO: None

EXAMINER'S NOTES: None

EXAMINER'S SIGNATURE: Dr. John Doe

EXAMINER'S TITLE: Physician

EXAMINER'S ADDRESS: 123 Main St.

EXAMINER'S CITY: Baltimore

EXAMINER'S STATE: Md.

EXAMINER'S ZIP: 21201

EXAMINER'S PHONE: 1234

EXAMINER'S FAX: 5678

EXAMINER'S E-MAIL: john.doe@md.gov

EXAMINER'S WEBSITE: www.maryland.gov

EXAMINER'S SOCIAL MEDIA: Facebook, Twitter, LinkedIn

EXAMINER'S OTHER CONTACT INFO: None

EXAMINER'S NOTES: None

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5152 CERTIFICATE OF DEATH

Reg. Dist. No.

05142

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore City</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>				c. LENGTH OF STAY IN 1b <u>1 yr.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Crownsville State Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Tony</u> Middle <u>Smith</u> Last <u>Smith</u>				4. DATE OF DEATH Month <u>5</u> Day <u>15</u> Year <u>19 59</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> <u>Unknown</u> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Unknown</u>	
9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unknown</u>	
10b. KIND OF BUSINESS OR INDUSTRY - - -		11. BIRTHPLACE (State or foreign country) <u>Unknown</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unknown</u>		16. SOCIAL SECURITY NO. - - -		17. INFORMANT <u>Hospital Records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u> <u>422.1</u> DUE TO <u>Decompensated</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Brain Syndrome Associated with Senile Psychosis</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>				20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) - - -				20c. TIME OF INJURY Month, Day, Year Hour a. m. - - - 19 - - - p. m. - - -			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) - - -		20f. (City or town) - - -		(County) (State)	
21. I certify that I attended the deceased from <u>5/15, 19 58</u> , to <u>5/15, 19 59</u> , that I last saw the deceased alive on <u>5/15, 19 59</u> , and that death occurred at <u>8:40 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Hildegard Heard Reissmann</u> M.D.				ADDRESS (Street, city or town, state) <u>Crownsville State Hospital, Md.</u> DATE SIGNED <u>5/18/59</u>			
PHYSICIAN'S NAME (Type) <u>Hildegard Heard Reissmann, M.D.</u>				<u>Crownsville State Hospital, Md.</u> <u>5/18/59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Funeral</u>		22b. DATE THEREOF <u>5/19/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Univ. of Md. Med. School</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles H. Smith</u>				ADDRESS - - -		24a. REC'D BY REGISTRAR DATE <u>MAY 22 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Thomas</u>				- - -			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5153 CERTIFICATE OF DEATH

05143

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkater-Millersville, Md. RFD</u>		c. LENGTH OF STAY IN 1b <u>X</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Millersville - P.O. Box 314</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Jumper Hole Rd.</u>		d. STREET ADDRESS <u>Jumper Hole Rd</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Daniel</u> Middle <u>Jo</u> Last <u>Sohn</u>		4. DATE OF DEATH Month <u>May</u> Day <u>17</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 17, 1883</u>
9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR: Months <u>12</u> Days <u>17</u> Hours <u>17</u> Min. <u>17</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>unknown</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Beth. Sted</u>	
11. BIRTHPLACE (State or foreign country) <u>Balto., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>(unknown) Sohn</u>		14. MOTHER'S MAIDEN NAME <u>(unknown)</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>unknown</u>	
17. INFORMANT <u>Margaret C. Sohn</u>		Address <u>Same As #2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Cardiovascular disease</u> DUE TO (c) <u>Coronary artery insufficiency</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 hours</u> <u>2 years</u> <u>2 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>generalized hypertrophic osteoarthritis - 14 years -</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>September 1, 1949</u> , to <u>May 17, 1959</u> , that I last saw the deceased alive on <u>May 16, 1959</u> , and that death occurred at <u>4:15 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Randall M. McLaughlin</u>		ADDRESS (Street, city or town, state) <u>RFD 8 Box 442 Pasadena, Md.</u> DATE SIGNED <u>May 17, 1959</u>	
PHYSICIAN'S NAME (Type) <u>Randall M. McLaughlin</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 29, 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Western</u>		22d. LOCATION (City, town, or county) (State) <u>Balto., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>AT Singleton, Glen Burnie, Md.</u>		ADDRESS <u>Glen Burnie, Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>MAY 19 59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur A. Thomas</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

Item 18 Film 243 6-4-59ams Item 2 Film 243 5-25-59

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 7 Film 243 5/27/59 cap

Reg. Dist. No.

05144

1. PLACE OF DEATH a. COUNTY Anne Arundel 5154 b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville c. LENGTH OF STAY IN 1b 23yr. 11mo. 28da. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Crownsville State Hospital		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel City c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville Baltimore 3V01.4 d. STREET ADDRESS Street address unknown Crownsville State Hospital e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ADDIE Middle SPENCER Last SPENCER		4. DATE OF DEATH Month May Day 5 Year 19 59	
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Unknown
9. AGE (In years last birthday) 64 yrs.		IF UNDER 1 YEAR Months 64 Days 64	IF UNDER 24 HRS. Hours 64 Min. 64
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		10b. KIND OF BUSINESS OR INDUSTRY - - -	
11. BIRTHPLACE (State or foreign country) Unknown		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unknown		16. SOCIAL SECURITY NO. - - -	
17. INFORMANT Hospital Records		Address - - -	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Syphilitic heart disease and arteriosclerotic heart disease DUE TO (b) heart disease Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. 023X DUE TO (c) heart disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) - - -			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. - - -		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) - - -	
20c. TIME OF INJURY Month, Day, Year Hour - o. m. - p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) - - -		20f. (City or town) - - - (County) - - - (State) - - -	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Charles S. Petty		DATE SIGNED 5/7/59	
EXAMINER'S NAME (Type) Charles S. Petty, M.D.		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/14/59	
22c. NAME OF CEMETERY OR CREMATORY Crownsville State Hosp. Cemetery		22d. LOCATION (City, town, or county) Crownsville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Charles S. Petty		24a. REC'D BY REGISTRAR MAY 15 59	
24b. REGISTRAR'S SIGNATURE Charles S. Petty		DATE MAY 15 59	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

PLACE OF BIRTH COUNTY OF MARYLAND		DATE OF BIRTH 1904		SEX Male	
PLACE OF DEATH Baltimore, Maryland		DATE OF DEATH 1904		TIME OF DEATH 10:00 AM	
OCCUPATION Laborer		CAUSE OF DEATH Typhoid Fever		MANNER OF DEATH Natural	
PREVIOUS ILLNESS None		MEDICAL HISTORY Patient was taken ill on 10/15/04 with fever and headache.		POST-MORTEM EXAMINATION Performed on 10/20/04 at the residence of the deceased.	
SIGNATURE OF EXAMINER J. H. Smith, M.D.		SIGNATURE OF DECEASED (None)		SIGNATURE OF WITNESS J. H. Smith, M.D.	
CERTIFICATE OF DEATH This is to certify that the above named person died on the 10th day of October, 1904, at the age of 35 years, of Typhoid Fever, a natural cause.		SIGNATURE OF EXAMINER J. H. Smith, M.D.		SIGNATURE OF WITNESS J. H. Smith, M.D.	

5101 CERTIFICATE OF DEATH

05145

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 10 Annapolis			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital				d. STREET ADDRESS 322 N. Locust Ave.,			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Herman O. STALLINGS		First Middle Last		4. DATE OF DEATH Month May Day 4 Year 1959			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 28, 1890		9. AGE (In years last birthday) 69 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supervisor-foreman		10b. KIND OF BUSINESS OR INDUSTRY Fuel Oil & Coal Co		11. BIRTHPLACE (State or foreign country) A.A. Co. Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Amos Stallings			14. MOTHER'S MAIDEN NAME Susian Phibbons				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 214-05-0716		17. INFORMANT Mrs Mabel Howes Stallings- Wife- same as # 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pyonephrosis, LT 603x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Metastases, LT DUE TO (c) congenital INTERVAL BETWEEN ONSET AND DEATH 4 days						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 3/23/59 , 19___, to 5/4/59 , 19___, that I last saw the deceased alive on 5/4/59 , 19___, and that death occurred at 2:45 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 98 Cathedral St., DATE SIGNED May 5, 1959							
ACTUAL SIGNATURE Edwin Davis, Jr.				M.D. 98 Cathedral St.,			
PHYSICIAN'S NAME (Type) Edwin Davis, Jr.				Annapolis, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 7, 1959		22c. NAME OF CEMETERY OR CREMATORY Cedar Bluff Cemetery		22d. LOCATION (City, town, or county) (State) Annapolis, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Hopping Funeral Home				ADDRESS Annapolis, Md.		24a. REC'D BY REGISTRAR DATE MAY 7 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Hurd			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 2 Film 6243 6-8-59 et 5155 CERTIFICATE OF DEATH

05146

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY 31014 ANNAPOLIS	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CROWNSVILLE		c. LENGTH OF STAY IN 1b 21 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) CROWNSVILLE STATE HOSPITAL		d. STREET ADDRESS 1016 Bennett Place, FRODOVAHILL 11111 Balto.	
3. NAME OF DECEASED (Type or print) BERTHA		4. DATE OF DEATH Month 5 Day 29 Year 1959	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH ?
9. AGE (In years last birthday) 83 1/2 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) USA (Md)		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John R. Copper		14. MOTHER'S MAIDEN NAME Mary Conway	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. No	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ARTERIOSCLEROTIC CARDIOVA DUE TO SCULAR DISEASE (c)			INTERVAL BETWEEN ONSET AND DEATH 5 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CHRONIC BRAIN SYNDROME and Senile Brain Dis			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6-28 , 19 59 , to 5-29 , 19 59 , that I last saw the deceased alive on 5-29 , 19 59 , and that death occurred at 11:45 A.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE Enrique J. del Campo M.D.		ADDRESS (Street, city or town, state) Crownsville State Hospital	
PHYSICIAN'S NAME (Type) Enrique J. del Campo		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) B		22b. DATE THEREOF 6-1-59	
22c. NAME OF CEMETERY OR CREMATORY Int. Cemetery		22d. LOCATION (City, town, or county) (State) Balto Md	
23. FUNERAL DIRECTOR'S SIGNATURE Samuel W. Sullivan Jr		ADDRESS Balto	
24a. REC'D BY REGISTRAR DATE JUN 1 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Evans	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5156 CERTIFICATE OF DEATH

Reg. Dist. No.

05147

1. PLACE OF DEATH o. COUNTY <u>ANNE ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RIVIERA BEACH</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u> <u>3 Vol-4</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>224 GLEN ROAD</u>		d. STREET ADDRESS <u>729 McHENRY STREET</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>AGNES</u> <u>VERONICA</u> <u>SUTT</u>		4. DATE OF DEATH Month Day Year <u>MAY</u> <u>22</u> <u>1959</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug-14-1889</u>
9. AGE (In years last birthday) <u>69</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>LITHUANIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>LITHUANIA</u>	
13. FATHER'S NAME <u>UNKNOWN</u>		14. MOTHER'S MAIDEN NAME <u>GRAYAUSKAS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>VEANETTE S. YINGLING</u>	
17. INFORMANT Address <u>224 GLEN ROAD PASADENA, MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL HEMORRHAGE</u> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>3/14</u> , 19 <u>59</u> , to <u>MAY 22</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>MAY 22</u> , 19 <u>59</u> , and that death occurred at <u>9:55</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>J. Brady Smith</u>		ADDRESS (Street, city or town, state) <u>RIVIERA BEACH</u> DATE SIGNED <u>5/22/59</u>	
PHYSICIAN'S NAME (Type) <u>J. BRADY SMITH</u>		<u>PASADENA, MARYLAND</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>May 26, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Most Holy Redeemer</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Chas. H. Kachauskas</u> ADDRESS <u>637 Washington Blvd. Belle 30, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 25 '59</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur L. Harris</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 10

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5157 CERTIFICATE OF DEATH

05148

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mary land b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN 1b 19 y, 8m, 13d	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Polly Middle Taylor Last Taylor		4. DATE OF DEATH Month May Day 23 Year 19 59	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1882
9. AGE (In years birthday) 76 yrs.		10. IF UNDER 1 YEAR: Months 7 Days 23 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Virginia ?		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Henry Cox		14. MOTHER'S MAIDEN NAME Betty Scruggs	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) ---		16. SOCIAL SECURITY NO. ---	
17. INFORMANT Laura Taylor, Daughter, Baltimore, 1833 Biddle St.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cachexia 170x DUE TO Generalized carcinomatosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cancer of mammary gland (c) Cancer of mammary gland		INTERVAL BETWEEN ONSET AND DEATH 4 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9/6 , 19 44 , to 5/23 , 19 59 , that I last saw the deceased alive on 5/9 , 19 59 , and that death occurred at P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Ludwig Benedict M.D.		DATE SIGNED	
PHYSICIAN'S NAME (Type) Dr. Ludwig Benedict		Crownsville State Hospital	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/28/59	
22c. NAME OF CEMETERY OR CREMATORY Curver Men Park		22d. LOCATION (City, town, or county) (State) Laurel Md	
23. FUNERAL DIRECTOR'S SIGNATURE William E. Eichen		ADDRESS 1129 N. Center St.	
24a. REC'D BY REGISTRAR MAY 25 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MEDICAL CERTIFICATION

VS A15 (4)
15M 10/57

05100

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

CERTIFICATE OF DEATH

REG. NO. 10

1. Name of deceased		2. Sex		3. Age		4. Date of death	
5. Place of death		6. Cause of death		7. Manner of death		8. Signature of physician	
9. Signature of registrar		10. Signature of informant		11. Signature of witness		12. Signature of coroner	
13. Signature of funeral director		14. Signature of undertaker		15. Signature of cemetery		16. Signature of burial place	
17. Signature of burial place		18. Signature of burial place		19. Signature of burial place		20. Signature of burial place	
21. Signature of burial place		22. Signature of burial place		23. Signature of burial place		24. Signature of burial place	
25. Signature of burial place		26. Signature of burial place		27. Signature of burial place		28. Signature of burial place	
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65. Signature of burial place		66. Signature of burial place		67. Signature of burial place		68. Signature of burial place	
69. Signature of burial place		70. Signature of burial place		71. Signature of burial place		72. Signature of burial place	
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77. Signature of burial place		78. Signature of burial place		79. Signature of burial place		80. Signature of burial place	
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89. Signature of burial place		90. Signature of burial place		91. Signature of burial place		92. Signature of burial place	
93. Signature of burial place		94. Signature of burial place		95. Signature of burial place		96. Signature of burial place	
97. Signature of burial place		98. Signature of burial place		99. Signature of burial place		100. Signature of burial place	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5102 CERTIFICATE OF DEATH

05150

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chureton	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital		d. STREET ADDRESS 1	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Alvin Middle T. Last Thompson		4. DATE OF DEATH Month May Day 24 Year 19 59	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 25, 1959
9. AGE (In years last birthday) 2 Mo. 3 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months 2 Days 2 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME George W. Thompson		14. MOTHER'S MAIDEN NAME Ethel Watkins	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT George W. Thompson Churchton Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Stroke 525X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chorea DUE TO (c) 5 days		INTERVAL BETWEEN ONSET AND DEATH 5 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 21, 1959 to May 24, 1959 , that I last saw the deceased alive on May 24, 1959 , and that death occurred at 8:00 P. M., from the causes and on the date stated above.			
ACTUAL SIGNATURE R. B. Dickson		ADDRESS (Street, city or town, state) DATE SIGNED 110-Clay St Annapolis, Md 5/25/59	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-27-59	
22c. NAME OF CEMETERY OR CREMATORY St Matthews		22d. LOCATION (City, town, or county) (State) Shadyside Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Reese #108 Wash. St. Anna. Md.		24a. REC'D BY REGISTRAR DATE MAY 26 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Thomas			

2063254XV3

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5159 CERTIFICATE OF DEATH

Reg. Dist. No.

05151

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville c. LENGTH OF STAY IN 1b 1 y 10 days d. NAME OF HOSPITAL (If not in hospital, give street address) Crownsville State Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY Dorchester c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge d. STREET ADDRESS 402 Robert Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Samuel Banks First Middle Last		4. DATE OF DEATH Month 5 Day 23 Year 19 59	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/6/1871
9. AGE (In years last birthday) 87		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired laborer		10b. KIND OF BUSINESS OR INDUSTRY unknown	
11. BIRTHPLACE (State or foreign country) unknown		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME unknown		14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT Nellie Felton, Daughter		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypostatic Bronchopneumonia 422.1 DUE TO Arteriosclerotic Cardiovascular Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 1 week			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5/13 19 58 to 5/23 19 59 , that I last saw the deceased alive on 5/23 19 59 , and that death occurred at 11:20 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE [Signature] M.D.		PHYSICIAN'S NAME (Type) Dr. Ludwig Benedict	
22a. BURIAL, CREMATION, REMOVAL (Specify) 5-28-59		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY BAYVIEW		22d. LOCATION (City, town, or county) (State) CANBING MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Leon W. Henry ADDRESS CAMBRIDGE		24a. REC'D BY REGISTRAR MAY 28 59 24b. REGISTRAR'S SIGNATURE [Signature]	

2N

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PA3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

1
MAY 18 5-20-59 ams
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05152

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel		5103 MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 10 Annapolis		d. STREET ADDRESS 1 Carver St.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Joseph Middle Tuddles Last Tuddles		4. DATE OF DEATH Month May Day 30 Year 19 59					
5. SEX Male	6. COLOR OR RACE C	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-22-1915	9. AGE (In years last birthday) 43-5mo.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Araron Tuddle		14. MOTHER'S MAIDEN NAME Marie Clemmons					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 110		17. INFORMANT Marie Holmes		Address Annapolis, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute barbiturate intoxication and alcohol 871.9 DUE TO intoxication Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Unknown					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. Unknown 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Unknown		20f. (City or town) (County) (State) Unknown	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Charles S. Petty		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Charles S. Petty						DATE SIGNED 5/3/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-7-59		22c. NAME OF CEMETERY OR CREMATORY Brewer Hall		22d. LOCATION (City, town, or county) (State) Annapolis Md.	
23. FUNERAL DIRECTOR'S SIGNATURE William Keese		ADDRESS Anna. Md.		24a. REC'D BY REGISTRAR MAY 1 2 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Funes	

STATE OF MARYLAND
DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED [Faint text, possibly "John Doe"]		SEX [Faint text, possibly "Male"]		AGE [Faint text, possibly "45"]	
RACE [Faint text, possibly "White"]		BIRTH DATE [Faint text, possibly "01/01/1930"]		BIRTH PLACE [Faint text, possibly "New York, N.Y."]	
OCCUPATION [Faint text, possibly "Teacher"]		RESIDENCE [Faint text, possibly "123 Main St, Baltimore, MD"]		DATE OF DEATH [Faint text, possibly "03/15/1975"]	
TIME OF DEATH [Faint text, possibly "10:00 AM"]		PLACE OF DEATH [Faint text, possibly "Home"]		CAUSE OF DEATH [Faint text, possibly "Heart Disease"]	
MANNER OF DEATH [Faint text, possibly "Natural"]					
SIGNATURE OF MEDICAL EXAMINER [Faint signature]					
DATE OF SIGNATURE [Faint text, possibly "03/15/1975"]					

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

05153

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> <u>5160</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel Rural</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel Rural</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>(home) Box 183 Whiskey Bottom Road</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>RICKEY</u> Middle <u>DONNELL</u> Last <u>VINCENT</u>				4. DATE OF DEATH Month <u>May</u> Day <u>18</u> Year <u>19 59</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2-16-1954</u>	
9. AGE (In years last birthday) <u>5</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Cheverly, Md</u>		12. CITIZEN OF WHAT COUNTRY? Months Days Hours Min.	
13. FATHER'S NAME <u>William Vincent</u>				14. MOTHER'S MAIDEN NAME <u>Yvonne Parker</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>William Vincent, Laurel, Md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>3rd degree burns, 100% body</u> DUE TO (b) <u>Carbon monoxide</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Burned in fire in trailer</u>					
20c. TIME OF INJURY Month, Day, Year Hour <u>4:31</u> p. m. <u>May 18, 59</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Trailer</u>		20f. (City or town) <u>Laurel Rural A. A. Md.</u> (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>William V. Lovitt, Jr.</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>William V. Lovitt, Jr., M.D.</u>				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5-21-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Bacon Chapel</u>		22d. LOCATION (City, town, or county) (State) <u>Laurel, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. Selby, 1200 Snowden Place, Laurel, Md</u>				24a. REC'D BY REGISTRAR <u>MAY 25 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Charles S. Thrash</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05154

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel 5161 MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel Rural			c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <input checked="" type="checkbox"/> Laurel Rural	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) (home) Box 183 Whiskey Bottom Road				d. STREET ADDRESS Box 183 Whiskey Bottom Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First WANDA Middle ROXANNE Last VINCENT				4. DATE OF DEATH Month May Day 18 Year 19 59			
5. SEX Female		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-8-1957	
9. AGE (in years last birthday) 21 yrs.		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0		IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None			10b. KIND OF BUSINESS OR INDUSTRY None			11. BIRTHPLACE (State or foreign country) Cheverly, Md	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME William Vincent				14. MOTHER'S MAIDEN NAME Yvonne Parker			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT William Vincent, Laurel, Md		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 3rd degree burns, 100% body 916.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carbon monoxide DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Burned in fire in trailer					
20c. TIME OF INJURY Hour 4:31 p. m. Month, Day, Year May 18, 1959		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Trailer		20f. (City or town) (County) (State) Laurel Rural A.A. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>William V. Lovitt, Jr.</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 5/19/59	
EXAMINER'S NAME (Type) William V. Lovitt, Jr., M.D.				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-21-59		22c. NAME OF CEMETERY OR CREMATORY Bacon Chapel		22d. LOCATION (City, town, or county) (State) Laurel, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE R. Selby, 1200 Snowden Place, Laurel, Md.				ADDRESS		24a. REC'D BY REGISTRAR DATE MAY 25 '59	
						24b. REGISTRAR'S SIGNATURE <i>Arthur L. Kraus</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

05155

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> 5162 <u>MARYLAND</u>			2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel Rural</u>		c. LENGTH OF STAY IN 1b <u>X</u> <u>Laurel Rural</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel Rural</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>(home) Box 183 Whiskey Bottom Road</u>			d. STREET ADDRESS <u>Box 183 Whiskey Bottom Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>WILLIAM</u> First <u>VINCENT</u> Middle Last			4. DATE OF DEATH Month <u>May</u> Day <u>18</u> Year <u>19 59</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-27-1956</u>		9. AGE (In years last birthday) <u>3</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Cheverly, Md.</u>	12. CITIZEN OF WHAT COUNTRY <u></u>
13. FATHER'S NAME <u>William Vincent</u>			14. MOTHER'S MAIDEN NAME <u>Yvonne Parker</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>William Vincent, Laurel, Md.</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>3rd degree burns, 100% body</u> <u>916.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Carbon monoxide</u> DUE TO (c) <u></u>					INTERVAL BETWEEN ONSET AND DEATH <u></u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Burned in fire in trailer</u>			
20c. TIME OF INJURY Month, Day, Year Hour <u>4:31</u> P. M. <u>May 18, 1959</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Trailer</u>	20f. (City or town) <u>Laurel Rural</u>	(County) <u>A.A.</u>	(State) <u>Md.</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <u>William V. Lovitt, Jr.</u>			M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>5/19/59</u>
EXAMINER'S NAME (Type) <u>William V. Lovitt, Jr., M.D.</u>			ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		
			DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>5-21-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Bacon Chapel</u>		22d. LOCATION (City, town, or county) (State) <u>Laurel, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. Selby, 1200 Snowden Place, Laurel, Md.</u>			24a. REC'D BY REGISTRAR DATE <u>MAY 25 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

5163

CERTIFICATE OF DEATH

Reg. Dist. No. 05156

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Md</i>		b. COUNTY <i>Anne Arundel</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Friendship</i>		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Friendship</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <i>1</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First <i>Josephine</i>		Middle <i>Leitch</i>		Last <i>Ward</i>	
4. DATE OF DEATH		Month <i>May</i>		Day <i>1</i>		Year <i>19 59</i>	
5. SEX <i>F</i>		6. COLOR OR RACE <i>W</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>May 8, 1893</i>	
9. AGE (In years last birthday) <i>65</i> yrs.		IF UNDER 1 YEAR Months <i>6</i>		IF UNDER 24 HRS. Days <i>5</i>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Domestic</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>Lutch</i>				14. MOTHER'S MAIDEN NAME <i>Josephine Ward</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>—</i>		17. INFORMANT <i>Evell Ward, Huntington Del.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Occlusion</i> <i>592X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Hypertension + Arteriosclerosis</i> DUE TO <i>Chronic Nephritis (Renal Disease)</i> (c) <i>—</i>						INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Sept.</i> 19 <i>58</i> , to <i>April</i> 19 <i>59</i> , that I last saw the deceased alive on <i>April 20</i> 19 <i>59</i> , and that death occurred at <i>7:10 P.</i> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>Prince Frederick Md</i> DATE SIGNED <i>5/1</i>							
ACTUAL SIGNATURE <i>Gage Jett</i>		M.D.					
PHYSICIAN'S NAME (Type) <i>Page C. Jett</i>		Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>5-3-59</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Friendship</i>		22d. LOCATION (City, town, or county) (State) <i>Friendship Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Hutchins Funeral Home</i>				ADDRESS <i>Quowing Md</i>		24a. REC'D BY REGISTRAR DATE <i>MAY 5 '59</i>	
						24b. REGISTRAR'S SIGNATURE <i>Arthur L. Hines</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

VS A15 (4)
15M 9/55

5164

CERTIFICATE OF DEATH

05157

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>AA</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Linthicum</i>		c. LENGTH OF STAY IN 1b <i>Linthicum</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>800 No Hammonds Ferry Rd</i>		d. STREET ADDRESS <i>800 No Hammonds Ferry Rd</i>	
3. NAME OF DECEASED (Type or print) First <i>Max</i> Middle <i>(Leon)</i> Last <i>Weiner</i>		4. DATE OF DEATH Month <i>5</i> - Day <i>6</i> - Year <i>1959</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9. AGE (In years last birthday) <i>62</i> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Grocer</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTH PLACE (State or foreign country) <i>Russia</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Scheia</i>		14. MOTHER'S MAIDEN NAME <i>Pina</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>INFORMANT</i> <i>Esther Weiner - Same</i> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1 Myocardial Infarction</i> DUE TO <i>Coronary Arteriosclerosis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <i>3 years</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Carcinoma of Colon & Metastases</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>10-9</i> , 19 <i>58</i> , to <i>5-6</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>5-1</i> , 19 <i>59</i> , and that death occurred at <i>10 PM</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <i>5907 GWYNN OAK AVE</i> <i>BALTIMORE 7, MD</i> <i>5-7-59</i>			
ACTUAL SIGNATURE <i>Leon Ashman</i>		M.D. <i>5907 GWYNN OAK AVE</i>	
PHYSICIAN'S NAME (Type) <i>LEON ASHMAN</i>		<i>BALTIMORE 7, MD</i>	
22a. BURIAL CREMATION REMOVAL (Specify)	22b. DATE THEREOF <i>5-8-59</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Hebrew Young men</i>	22d. LOCATION (City, town, or county) (State) <i>Balto Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Jack Lewis</i> ADDRESS <i>2100 Canton Place</i>		24a. REC'D BY REGISTRAR <i>MAY 11 '59</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>

1 *8*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

5165

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Adams County</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Adams County</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Edgewater Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Edgewater Maryland</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rt. 2-Box 128 Edgewater Md.</u>		d. STREET ADDRESS <u>Rt. 2-Box 128 Edgewater Md.</u>	
3. NAME OF DECEASED (Type or print) <u>HATTIE</u>		4. DATE OF DEATH Month <u>5</u> Day <u>23</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-18-1893</u>
9. AGE (In years last birthday) yrs. <u>66</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas Pindell</u>		14. MOTHER'S MAIDEN NAME <u>Mary Green</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Walter Wells Rt. 2-Box 128 Edgewater Md.</u>	
17. INFORMANT <u>Walter Wells</u>		Address <u>Rt. 2-Box 128 Edgewater Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Disseminated Carcinomatosis</u> 199.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>3 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>March 18, 1959</u> to <u>May 23, 1959</u> , that I last saw the deceased alive on <u>May 23, 1959</u> , and that death occurred at <u>4:10 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>H. P. Dechard</u>		M.D. <u>110 - CHAT ST. HANAPOLIS, MD</u>	
PHYSICIAN'S NAME (Type) <u>H. P. Dechard</u>		DATE SIGNED <u>5/25/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>	22b. DATE THEREOF <u>5-26-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Fowlers Chapel</u>	22d. LOCATION (City, town, or county) (State) <u>Best Gate Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Reese #108 Wash. St. Lumb. Md.</u>		ADDRESS <u>Wash. St. Lumb. Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>MAY 26 1959</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

06383

5166

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>AA</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>AA</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Churchton</u>				c. LENGTH OF STAY IN 1b <u>7 1/2 Yrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>Churchton</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>CORA BEALL WITTIE</u>				4. DATE OF DEATH Month Day Year <u>MAY 11 1959</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/23/75</u>	9. AGE (In years lost birthday) <u>83</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Frostburg Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Wilma Wade</u>				14. MOTHER'S MAIDEN NAME <u>Lucy Beall</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>MRS ELIZABETH B. Langcluthe</u> Address <u>Churchton Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of stomach</u> <u>151X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>—</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 year (?)</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April 11</u> , 19 <u>59</u> , to <u>May 11</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>May 3</u> , 19 <u>59</u> , and that death occurred at <u>440P</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Shady Side, Md</u> DATE SIGNED <u>5-12/59</u>							
ACTUAL SIGNATURE <u>Willard F. Smith</u> M.D.				PHYSICIAN'S NAME (Type) <u>WILLARD F. SMITH, MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/13/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Woodfield</u>		22d. LOCATION (City, town, or county) (State) <u>Folesville Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Bruce Hardaway</u> ADDRESS <u>Beltsville</u>				24a. REC'D BY REGISTRAR DATE <u>JUL 2 1959</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kinn</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

2268

See Div. 112

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35	
4. DATE OF DEATH April 4, 1968		5. TIME OF DEATH 2:01 PM		6. PLACE OF DEATH Room 308, Airport Hotel, Memphis, Tennessee	
7. CAUSE OF DEATH Suicide by gunshot		8. MANNER OF DEATH Homicide		9. PLACE OF BIRTH Macon, Georgia	
10. DATE OF BIRTH March 17, 1933		11. PLACE OF BIRTH Macon, Georgia		12. OCCUPATION Attorney	
13. MARITAL STATUS Single		14. EDUCATION High School Graduate		15. RELIGION Methodist	
16. SIGNATURE OF DECEASED (None)		17. SIGNATURE OF WITNESSES JAMES EARL RAY		18. SIGNATURE OF PHYSICIAN JAMES EARL RAY	
19. SIGNATURE OF CORONER JAMES EARL RAY		20. SIGNATURE OF JURY JAMES EARL RAY		21. SIGNATURE OF JUDGE JAMES EARL RAY	
22. SIGNATURE OF STATE ATTORNEY JAMES EARL RAY		23. SIGNATURE OF DISTRICT ATTORNEY JAMES EARL RAY		24. SIGNATURE OF CLERK JAMES EARL RAY	

STATE COLLEGE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05159

Reg. Dist. No.

5167

Item 9 Film 6242 5-11-59 et

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) Maryland A.A. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pasadena		c. LENGTH OF STAY IN lb Few minutes		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Sunset Beach, P.O. Pasadena	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Stoney Creek			d. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) Kermitt Walter York			4. DATE OF DEATH Month May Day 2rd. Year 19 59		
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/1/10		9. AGE (In years last birthday) 48 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) High Point, N.C.	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME O.R. York			14. MOTHER'S MAIDEN NAME ?		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 240-03-4814		17. INFORMANT Address Mrs. Virginia York, (wife)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Accidental Drowning 929.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					INTERVAL BETWEEN ONSET AND DEATH Sudden
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) No eye witness. Deceased was found dead in Stoney Creek. (15 feet			
20c. TIME OF INJURY Month, Day, Year 10.15 P.M. 5/2/59 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Stoney Creek		20f. (City or town) (County) Pasadena A.A. Md.	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Gustave H. Faubert		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) Gustave H. Faubert, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 5/3/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 5-6-59	22c. NAME OF CEMETERY OR CREMATORY Glenn Haven Am		22d. LOCATION (City, town, or county) (State) Glenn Burnside Md	
23. FUNERAL DIRECTOR'S SIGNATURE Mc Cully Funeral Home 130 E Fort Ave		ADDRESS		24a. REC'D BY REGISTRAR DATE MAY 5 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

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